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# Drawing Lines in Shifting Sands: The U.S. Supreme Court's Mixed Messages on ERISA Preemption Imperil Health Care Reform

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# DRAWING LINES IN SHIFTING SANDS:

## THE U.S. SUPREME COURT’S MIXED MESSAGES ON ERISA PREEMPTION IMPERIL HEALTH CARE REFORM

*Mary Ann Chirba–Martin, J.D., Sc. D., M.P.H.\**

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## I. INTRODUCTION

In January 2009, President Obama assumed office, Democrats assumed control of Congress, and many assumed that comprehensive health reform could be signed into law by the end of the year.<sup>1</sup> Political opponents and competing stakeholders alike aspired “to move from a nonsystem to a system of health care,”<sup>2</sup> and finally overcome “the health system’s chaotic disorganization.”<sup>3</sup> Whether federal reform *should* occur had become a given; debate now centered on *how* to pursue “the Four Cs” of “coverage, cost control, coordinated care, and choice.”<sup>4</sup> Not surprisingly, though, the always difficult task of health reform proved even more challenging when competing with economic recession, rising unemployment, foreign wars, and spiraling deficits for scarce political and financial capital. Thus, by the 111<sup>th</sup> Congress’ August 2009 recess, early enthusiasm for reform had devolved to distaste for hard—and expensive—choices, making it increasingly likely that federal action, if any, would leave much unresolved.

Whether measured or bold, effective reform must target the causes of the U.S. “nonsystem” and so far, Congress has paid scant attention to a fundamental one: ERISA preemption of state law. Since its enactment in 1974, the Employee Retirement Income Security Act’s preemption language has been endlessly and inconsistently interpreted by the U.S. Supreme Court—sometimes to protect patients,<sup>5</sup> but more often to shield health payers, particularly managed care organizations, from accountability for their decisions regarding who will be treated and who will be paid for providing that treatment.<sup>6</sup> In a nation where most people

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1. Sheryl Gay Stolberg, *Obama Taps Clinton Ideas but Not Clinton Herself*, N.Y. TIMES, Mar. 5, 2009, at A19 (“Experts say the political climate for passing major health care changes is more favorable than ever, with business leaders, pharmaceutical and hospital executives, insurance officials and advocates for patients all agreeing the need is urgent.”).

2. Denis Cortese & Jeffrey O. Korsmo, *Health Care Reform: Why We Cannot Afford to Fail*, 28 HEALTH AFFAIRS w173, w174, available at [http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp\\_type=&author1=cortese&fulltext=health+care+reform&pubdate\\_year=&volume=&firstpage=](http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp_type=&author1=cortese&fulltext=health+care+reform&pubdate_year=&volume=&firstpage=) (follow hyperlink to PDF) (last visited Oct. 26, 2009).

3. Henry J. Aaron, *The Pitfalls of Overreaching in Health Reform*, 28 HEALTH AFFAIRS w184, w185, available at [http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp\\_type=&author1=aaron&fulltext=overreaching+in+health+reform&pubdate\\_year=&volume=&firstpage=](http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp_type=&author1=aaron&fulltext=overreaching+in+health+reform&pubdate_year=&volume=&firstpage=) (follow hyperlink to PDF) (last visited Oct. 17, 2009).

4. Victor R. Fuchs, *Health Reform: Getting the Essentials Right*, 28 HEALTH AFFAIRS w180, available at [http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp\\_type=&author1=fuchs&fulltext=Health+Reform%3A+Getting+the+Essentials+Right&pubdate\\_year=&volume=&firstpage=](http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp_type=&author1=fuchs&fulltext=Health+Reform%3A+Getting+the+Essentials+Right&pubdate_year=&volume=&firstpage=) (follow hyperlink to PDF) (last visited Oct. 17, 2009).

5. See *infra* note 188 and accompanying text.

6. See *infra* notes 165 and 210 and accompanying text.

already receive health coverage through employer-sponsored benefits plans and many more will do so should Congress enact an employer mandate, ERISA preemption is a major reason for a nonsystem that too frequently harms patients, frustrates providers, and undermines state efforts to impose order on the resulting “chaotic disorganization.”<sup>7</sup> Yet, ERISA preemption reform has been virtually absent from the health reform debate, although it is not clear why.<sup>8</sup> Perhaps this reflects a pragmatic determination by lawmakers to effect change without making “perfect the enemy of the absolutely necessary.”<sup>9</sup> Perhaps Congress erroneously views ERISA preemption as no longer being a problem once it passes individual and/or employer coverage mandates. Or perhaps ERISA’s wider impact on health care is being overlooked or underplayed simply because it is too complex and confounding to appreciate, let alone fix. Whatever the reasons, the results are clear: the laudable goal of expanding coverage will only compound existing problems for patients and providers in dealing with health care payers. Thus, federal legislators must address ERISA preemption to ensure managed care accountability to patients and providers. Clarification of ERISA’s preemptive reach is also needed to spell out the role of states in health care oversight since, with no single payer option on the table, current reform efforts will inevitably require both federal and state regulation of health care.<sup>10</sup> This article will clarify why and how to do just that.

The process by which ERISA preemption has deprived patients of their health benefits, denied providers reimbursement, and derailed too many promising state efforts to improve the “Four Cs” of “coverage, cost control, coordinated care, and choice” has been a long and tortured one. This article begins with the mechanics of ERISA preemption and then examines the evolution

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7. See Aaron, *supra* note 3.

8. To the extent ERISA reform has been discussed in the context of national health reform, it has tended to focus on whether self-insured plans will continue to enjoy a lack of governmental oversight. See, e.g., Opinion, *Repealing ERISA*, WALL ST. J., July 20, 2009, available at [http://online.wsj.com/article/SB10001424052970203946904574298661486528186.html?mod=google\\_news\\_wsj](http://online.wsj.com/article/SB10001424052970203946904574298661486528186.html?mod=google_news_wsj) (last visited Oct. 26, 2009).

9. Remarks of President Barack Obama, Weekly Address, The White House (Feb. 7, 2009) available at [http://www.whitehouse.gov/blog\\_post/compromise1/](http://www.whitehouse.gov/blog_post/compromise1/) (last visited Oct. 26, 2009) (lauding the Senate for reaching a compromise on his economic recovery plan because “we can’t afford to make perfect the enemy of the absolutely necessary.”). President Obama’s comment is one of many variations of a quote attributed to the philosopher Voltaire who stated in his *DICTIONNAIRE PHILOSOPHIQUE* (1764) “[l]e mieux est l’ennemi du bien, bien” (translating literally as “the best is the enemy of the good,” but often rephrased as “the perfect is the enemy of the good.”).

10. See Alan Weil, *A New Approach to the State-Federal Relationship in Health*, 28 HEALTH AFFAIRS, w188, w192, available at [http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp\\_type=&author1=weil&fulltext=A+New+Approach+to+the+State-Federal+Relationship+in+Health&pubdate\\_year=&volume=&firstpage=](http://content.healthaffairs.org/cgi/search?andorexactfulltext=and&resourcetype=1&disp_type=&author1=weil&fulltext=A+New+Approach+to+the+State-Federal+Relationship+in+Health&pubdate_year=&volume=&firstpage=) (follow hyperlink to PDF) (last visited Oct. 17, 2009).

of ERISA's preemptive effect on managed care in particular and health policy in general. It does so by categorizing an unwieldy body of case law into seven stages that trace the courts' progression from no preemption of state law claims against managed care payers, to broad preemption, retreating to limited preemption and, for now at least, trending again toward broad preemption.

During the first stage of litigation, health maintenance organizations [HMOs] were novel entities and lower courts readily adapted theories of direct and vicarious hospital liability to hold them liable for patient treatment decisions; ERISA preemption was not even raised as a defense.<sup>11</sup> After ERISA had existed for at least a decade without intersecting with HMO liability claims, a second stage unfolded. Relying on non-health benefits rulings by the U.S. Supreme Court, creative defense attorneys argued successfully that ERISA broadly preempted the kinds of HMO liability claims that could be asserted against hospitals.<sup>12</sup> Judicial struggle characterizes the third and fourth stages as courts sought to follow the Supreme Court's twists and turns concerning the scope of ERISA's complete and conflict preemption of state law regarding what had become known as managed care organizations (MCOs).<sup>13</sup>

A brief fifth stage saw creative lawyering at work once again, but this time on behalf of patients. Faced with mounting failures in overcoming ERISA preemption of state law remedies, the plaintiff's bar invoked ERISA's own civil enforcement provisions, but the strategy failed when the U.S. Supreme Court changed course yet again.<sup>14</sup> This portended tighter limits on ERISA preemption with an attendant expansion of state law remedies, particularly for patient tort claims arising out of medical necessity determinations.<sup>15</sup> Sadly for patients, providers, and state legislators, though, a sixth stage shows the Supreme Court returning to the expansive ERISA preemption of earlier days.<sup>16</sup> Along the way, unsustainable increases in health care costs and the uninsured along with congressional intransigence have incited states to take the lead in expanding coverage, improving access and controlling costs. Whether ERISA will preempt such measures is the focus of an emerging seventh stage of judicial inconsistency that will generate even more confusion unless Congress implements comprehensive reform and/or loosens the

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11. See *infra* notes 44–53 and accompanying text.

12. See *infra* notes 54–74 and accompanying text.

13. See *infra* notes 75–153 and accompanying text.

14. See *infra* notes 145–210 and accompanying text.

15. See *infra* note 165 and accompanying text.

16. See *infra* note 211–55 and accompanying text.

ERISA ties now binding the states.<sup>17</sup>

Collectively these stages reveal that whether Congress enacts comprehensive reform or moves more incrementally, it must confront ERISA preemption directly and explicitly recalibrate the roles of federal and state governments in overseeing health care. Truly comprehensive reform, albeit an earlier goal that seems increasingly unlikely, might exert so much federal control as to displace state law entirely. A more likely result would leave state law intact, at least with regard to individual patient-MCO and/or provider-MCO disputes, and perhaps in other respects, too. Consequently, the most likely result of federal reform or no reform at all is the same: states will continue to partner with the federal government in regulating health care. And with or without federal reform, states need greater freedom or at least greater clarity as to how to operate effectively given the specter of ERISA preemption. Congress can address this by amending ERISA's preemption provisions and/or liberalizing the availability of ERISA waivers, but it must not pursue the "Four Cs" at the expense of patients, providers, and the states. When it comes to ERISA, its current strategy of saying little and doing less is akin to expecting the ERISA preemption elephant to leave the room on its own accord. But, as explained below, thirty five years of litigation demonstrate unequivocally that this elephant will continue to trample patients and providers, and hamper state innovation and oversight unless and until Congress shows it the door.

## II. DISCUSSION

### *a. Background and Mechanics of ERISA Preemption*

Prior to ERISA's enactment in 1974, states regulated the formation and administration of employee pension plans in an often complex and frequently inconsistent manner.<sup>18</sup> Even well-meaning plan administrators could easily mismanage a plan in the face of conflicting state directives, and dishonest plan administrators had ample opportunities to under-fund or misdirect plan assets. In response, Congress passed the Employee Retirement Income Security Act of 1974<sup>19</sup> to protect employee benefit plan participants and their beneficiaries by federalizing,

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17. See *infra* notes 287–347 and accompanying text.

18. See, e.g., 120 CONG. REC. 29, 197 (1974) (statements of Sen. Williams that ERISA's "substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans."); *id.* (statement of Sen. Dent that preemption "eliminate[s] the threat of conflicting and inconsistent State and local regulation.").

19. *Id.*; 29 U.S.C. §§ 1001–1461 (2006).

and supposedly simplifying, regulation of plan administration. As the United States Supreme Court stated in *Ingersoll-Rand Co. v. McClendon*, Congress intended, “to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government.”<sup>20</sup>

ERISA’s content reflects Congress’ focus on preventing fraud and mismanagement in plan administration.<sup>21</sup> As the U.S. Supreme Court has observed, ERISA “does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits . . . .”<sup>22</sup> Rather, ERISA controls the administration of benefit plans through its detailed provisions concerning plan design and administration (*e.g.*, reporting and disclosure requirements,<sup>23</sup> participation and vesting provisions,<sup>24</sup> funding standards<sup>25</sup> and the fiduciary obligations of plan administrators<sup>26</sup>). Given its purpose of controlling plan administration and its particular focus on pension plans, such detailed directives contrast starkly with its silence about the complexities of a plan participant’s ability to obtain quality health benefits.

To protect plan administrators from the untoward results of unduly complicated and potentially contradictory state regulations, ERISA also contains a three-part preemption provision. Section 514(a) states that ERISA shall “supersede any and all State laws insofar as they may now or hereafter ‘relate to’ an employee benefit plan . . . .”<sup>27</sup> “Saved” from the so-called “relate to” clause (or excluded from preemption) are those state laws that qualify, *inter alia*, as state insurance law.<sup>28</sup> However, states are precluded from “deeming” a law to constitute insurance regulation for the purpose of “saving” a law which would otherwise “relate to” a plan and trigger “relate to” preemption.<sup>29</sup> To further complicate matters, ERISA does not expressly define

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20. 498 U.S. 133, 142 (1990).

21. ERISA applies to employee welfare and pension benefit plans that provide “medical, surgical, or hospital care or benefits” for plan participants and their beneficiaries “through the purchase of insurance or otherwise.” 29 U.S.C. § 1002(1).

22. *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995) (hereinafter *Travelers*).

23. 29 U.S.C. §§ 1021-1031 (2006).

24. *Id.* at §§ 201-211.

25. *Id.* at §§ 301-308.

26. *Id.* at §§ 1131-1145.

27. Employee Retirement Income Security Act of 1974, § 514(a), 29 U.S.C. § 1144(a) (2006). State laws subject to possible preemption include “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.” *Id.* at § 1144(c)(1).

28. *Id.* at § 514(b)(2)(A), § 1444(b)(2)(A).

29. *Id.* at § 514(b)(2)(B), § 1444(b)(2)(B).

“relate to” and also fails to explain what constitutes state insurance law for the purposes of the savings and deemer clauses.

Initially, state efforts to invoke saving clause protection to regulate an emerging managed care industry provided small relief. In *Metropolitan Life Insurance Co. v. Massachusetts*,<sup>30</sup> the Supreme Court looked to its prior interpretation of similar language in the McCarron-Ferguson Act<sup>31</sup> and held that, to be saved, a state law would need to regulate “the business of insurance”<sup>32</sup> which itself needed to (1) transfer or spread the policyholder’s risk, (2) be integral to the insurer-insured relationship, and (3) be limited to insurance entities.<sup>33</sup> This meant that states could not regulate managed care entities that share financial risk instead of transferring or spreading risk as conventional insurers do. Also out of reach were managed care entities acting as third-party administrators (TPAs) for self-insured plans since self-insurers do not transfer actuarial risk to an independent entity.

Consistent with expansive preemption, many courts initially interpreted *Metropolitan Life* as requiring that all three McCarron-Ferguson factors had to be satisfied in order to qualify as the kind of state insurance regulation that could be saved from preemption.<sup>34</sup> Typically, a self-insured plan retains financial risk even though administrative functions may be delegated to a third party that may simultaneously serve as an indemnity insurer for other contracts. Thus, insured and self-insured plans may look virtually identical to plan beneficiaries since the same “players” may be involved. While subtle, the enormously significant technicalities of risk transfer mean that only conventionally insured plans are subject to state insurance regulation while self-insured plans are not.<sup>35</sup> When ERISA was enacted in 1974, self-insurance was seen as appealing only to large employers. Following 1985’s *Metropolitan Life* decision, however, plans of all sizes astutely recognized that self-insurance could evade state oversight. Seeing a growing market, indemnity insurers developed purely administrative products, making self-insurance feasible even for smaller plans. Not surprisingly, the number of

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30. 471 U.S. 724 (1985).

31. See 15 U.S.C. § 1012(a) (2006).

32. *Metro. Life*, 471 U.S. at 743.

33. *Id.* (relying on its prior interpretation of “the business of insurance” in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982), regarding state insurance law’s exemption from federal anti-trust oversight under the McCarron-Ferguson Act, 15 U.S.C. § 1012(a)).

34. See *infra* note 203 and accompanying text.

35. To illustrate, statements regarding an individual’s health care expenditures may be issued by Aetna Insurance without the patient ever appreciating whether Aetna is bearing the full financial risk (and, thus acting as an insurer), or simply acting as a third-party administrator of a separate self-insured plan.



self-insured plans quickly grew.

Section 514 preemption of state law and, therefore, state remedies, leave ERISA's section 502(a) civil enforcement scheme as the sole avenue of relief for negligent medical necessity and other benefits determinations. Appropriate relief would normally be found by filing a state tort claim for monetary damages, but under section 514, this is no longer possible since state tort or legislative relief would not be saved as limited to the business of insurance.<sup>36</sup> Yet, section 502 only permits equitable relief for obtaining benefits that have been denied or delayed. *Ex ante*, this can require a patient to pursue the plan's administrative appeals process and/or retain an attorney and seek preliminary injunctive relief while in the midst of a health crisis – a daunting process even for healthy claimants. *Ex post* equitable relief for a beneficiary who has suffered serious harm or death due to a denial or delay in receiving such benefits is obviously futile. Consequently, ERISA's section 514 preempts state remedies while section 502(a)(3)'s limited, "other equitable relief" precludes monetary damages even where equitable relief is so clearly hollow.<sup>37</sup>

A state tort remedy may still be available against a defendant (such as a treating physician) who is not shielded from suit through ERISA preemption. However, the age of managed care created a new liability scenario in which the patient and physician are often aligned against a managed care organization that seeks to block, limit, or change the care deemed medically necessary by the physician. No longer does a medical malpractice case necessarily pit an injured patient against an allegedly negligent physician because, in many cases, the patient has no cause of action against the doctor where the care itself was not negligently administered. Rather, the harm was rooted not in the quality of treatment rendered but in an HMO-determined treatment protocol that was not what the doctor had ordered. Thus, in a medical injury case based on a managed care (as opposed to a physician's) decision, *ERISA preemption of state law effectively leaves the injured party with no remedy.*

This result contradicts Congress' original intent of making ERISA an employee-protective statute. Despite the lack of any indication that Congress intended to leave patients with no meaningful remedies, recipients of health benefits through ERISA-qualified plans are cast into the so-called "ERISA vacuum" of no meaningful remedies and no sensible federal or state regulations

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36. See *infra* notes 184-210 and accompanying text.

37. See, e.g., *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 263 (1993) (monetary damages unavailable); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985) (unavailability of extra-contractual, compensatory, or punitive damages under section 502).

to preclude such plan behavior.<sup>38</sup> In contrast, HMO liability toward non-ERISA plan enrollees under state law is *not* compromised by ERISA preemption. The HMO's accountability under state tort law, therefore, varies with the ERISA status of the particular plan involved—a result that further contravenes congressional intent.

ERISA preemption affects managed care in a variety of ways that can be roughly—*very* roughly—divided into (1) quality and (2) provider contracting issues. State quality initiatives that have been preempted include mandated benefits, grievance requirements, and personal injury actions for HMO decisions directing or restricting medical care.<sup>39</sup> ERISA has also preempted state efforts to address provider-contracting issues such as any willing provider laws, de-selection criteria, and financial incentive and risk-sharing arrangements (which might also be placed in the quality category due to their influence on provider behavior and, therefore, patient care), as well as state initiatives to expand coverage.<sup>40</sup>

As a result, quirks in ERISA's structure and text, combined with inconsistent judicial interpretations have fueled the frustrations of patients, providers, and state legislators in dealing with managed care. Patients complain about perceived inadequacies in plan coverage and accountability, inciting adverse media coverage and litigation.<sup>41</sup> Providers are constrained in the practice of medicine and often have to fight for reimbursement.<sup>42</sup>

38. The earliest judicial mention of this term appears to have occurred in the non-health benefits case of *Gast v. Stevenson*, 585 P.2d 12, 22 (Or. Ct. App. 1978). For a more recent example, see *Pichoff v. QHG of Springdale, Inc.*, 556 F.3d 728, 732 (8th Cir. 2009).

39. For an overview of early ERISA preemption litigation, see Mary Ann Chirba-Martin & Troyen A. Brennan, *The Critical Role of ERISA in State Health Reform*, 13 HEALTH AFFAIRS 142 (1994).

40. *Id.* at 150–52.

41. Managed care denials of medical care have fueled several films, including 2002's "John Q." a fictional account of a father's desperate efforts to secure coverage for his son's heart transplant, and Michael Moore's 2007 documentary "Sicko" recounting myriad "HMO horror stories." JOHN Q. (New Line Cinema 2002); SICKO (Dog Eat Dog Films, Inc. 2007).

ABC News' Good Morning America and similar programs frequently cover such stories as well. See, e.g., Chris Cuomo & Gerry Wagschal, *Amputee Fights for Coverage of Prosthetics: GMA Helps Woman Get Special Prosthetic Legs After Insurance Company Denied Her*, ABC NEWS, Jan. 14, 2009, available at <http://abcnews.go.com/GMA/GetAnswers/story?id=6640663&page=1>.

See also Lisa Girion, *Insurer's Agreement to Cover Surgery Comes Too Late*, LA TIMES, Oct. 8, 2009, <http://articles.latimes.com/2009/oct/08/business/fi-cigna8>; *Health Insurer to Be Charged With Teen's Murder: California Family Will Sue Medical Insurer for Delaying a Potentially Lifesaving Surgery*, ABC NEWS, Dec. 21, 2007, available at <http://abcnews.go.com/GMA/CancerPreventionAndTreatment/story?id=4038257&page=1>

(reporting on attorney Mark Geragos's promise "to press murder or manslaughter charges" against Cigna HealthCare because it "'maliciously'" delayed approving a liver transplant for 17-year old Nataline Sarkisyan). The family's contract and unfair business practices claims were dismissed as preempted by sections 502 and 514, although their claim for intentional infliction of emotional distress survived. *Sarkisyan v. CIGNA Healthcare of Cal., Inc.*, 613 F. Supp. 2d 1199 (C.D. Ca. 2009).

42. See *infra* notes 234–55 and accompanying text.

In the meantime, many states have enacted as well as rejected various approaches to “regulating around” ERISA, but have had little, if any success.<sup>43</sup> Consequently, ERISA, an employee-protective statute, has become the mainstay for relieving plans of accountability for medical decisions, and has shifted the risk of harm to the patient/plan participant. Still, in juggling ERISA preemption, one point that is crucial to hold onto yet is so easily overlooked is that *whether a plan is conventionally or self-insured has no significance for preemption purposes unless the asserted law or claim first satisfies the “relate to” clause*. And it is precisely at this “starting gate” of ERISA preemption analysis that, in theory, the greatest gains can be made by the tort litigant or state rule maker. In practice, however, such possibilities have remained largely unrealized due to the inherent complexity of ERISA’s text, the inconsistency of the U.S. Supreme Court and other courts charged with its interpretation, and the political contentiousness of a federal legislative cure.

*b. The Stages of HMO Liability and the Phoenix of ERISA Preemption*

Stage 1: Parallel Play – HMO Liability and ERISA Preemption Peacefully Co-Exist

Despite efforts to integrate the finance and delivery of care since the 1930s—the hallmark feature that distinguishes managed care from fee-for-service indemnity insurance—managed care did not capture a significant share of the employee health insurance market until Congress passed the HMO Act of 1973.<sup>44</sup> That law sought to promote HMOs by offering financial incentives, lifting state impediments to HMO formation and enrollment, and requiring large and mid-size employers providing employee health benefits to offer an HMO option.<sup>45</sup> Notwithstanding these efforts, managed care did not achieve its present market dominance until the 1990s.<sup>46</sup>

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43. See *infra* notes 256-93 and 315-16 and accompanying text.

44. Federal HMO Act of 1973, 42 U.S.C. § 300e (1973). For an overview of the history of managed care before and after passage of the HMO Act, see Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J. L. & MED. 301, *passim* (1996).

45. 42 U.S.C. § 300(e) (1973).

46. In 1970, just 37 HMOs existed in fourteen (mostly western) states with enrollment totaling three million. Due to increased federal funding, looser federal requirements and structural diversification, HMOs neared 500 in number and twenty-five million in enrollment by 1987. Lynn R. Gruber, Maureen Shadle, & Cynthia L. Polich, *From Movement to Industry: The Growth of HMOs*, 7 HEALTH AFFAIRS 197, 197-99, 201 (1988). See also, Gail A. Jensen, et al., *The New Dominance of Managed Care: Insurance Trends In The 1990s*, 16 HEALTH AFFAIRS 125, 134 (1997) (reporting that by 1997, approximately 75% of employer-sponsored health coverage was provided through managed care plans).

Thus, when Congress debated and ultimately enacted ERISA in 1974, “employee health benefits” still consisted primarily of traditional indemnity/fee-for-service insurance. The ensuing permutations of integrating health care finance and delivery, the on-going development of cost control strategies that influence if not dictate the provision of health care, and the predominance of employer sponsorship of health benefits were simply too embryonic to influence Congress’ design of ERISA in 1974.<sup>47</sup> If anything, enacting ERISA and the HMO Act in the same time frame shows that Congress intended HMOs to be subject to the same oversight that states traditionally exercise over health care issues in general and health insurance in particular.

In the first decade following its enactment, litigants apparently thought so, too, as ERISA’s section 502 civil enforcement remedies and section 514’s “relate to” preemption clause peacefully co-existed with both the application of state law and the emerging industry of managed health care. In the earliest stage of managed care litigation, ERISA preemption was not even raised as a defense to state liability claims against HMOs or independent utilization reviewers for medical necessity determinations resulting in patient harm.<sup>48</sup> For example, the 1986 decision of *Wickline v. State of California* recognized the viability of a claim for an HMO’s negligent utilization review even though the facts did not support liability in that case.<sup>49</sup> Two years later, the Pennsylvania Superior Court ruled in *Boyd v. Albert Einstein Medical Center* that an HMO may be vicariously liable for medical malpractice through ostensible agency where the patient looks primarily to the HMO for care.<sup>50</sup> In the 1990 case of *Wilson v. Blue Cross of Southern California*, a claim for negligent utilization review was again permitted where utilization review denied coverage for an extended psychiatric hospitalization even though the treating physician deemed it medically necessary; the patient was discharged and committed suicide a few days later.<sup>51</sup> The court reasoned that there was no reason, public policy or otherwise, to exempt a utilization review company from tort liability where its actions otherwise satisfied the elements of a negligence claim.<sup>52</sup>

In applying conventional tort principles to the relatively novel entities of HMOs, UR companies, and other managed care organizations, the early state court opinions did not even mention ERISA preemption. Importing hospital liability principles into the

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47. See Gruber et al., *supra* note 46.

48. *Wickline v. State*, 239 Cal. Rptr 810 (Cal. Ct. App. 1986).

49. *Id.*

50. 547 A.2d 1229, 1234-35 (Pa. Super. Ct. 1988).

51. 271 Cal. Rptr. 876, 878 (Cal. Ct. App. 1990).

52. *Id.* at 884.

managed care context was just a typical example of how existing law evolves to address novel issues. In fact, in some ways, the case for HMO liability based on ostensible agency theories seemed to be on even firmer ground than hospital vicarious liability. While a hospital often has no relationship with a patient prior to that patient's entry, an HMO might enjoy years of a formal contractual relationship coupled with explicit documentary assertions of "caring" for the patient in the most literal sense of the word. Nevertheless, despite the common sense appeal of holding HMOs to the same theories of institutional liability that govern other health care entities, this first stage of HMO liability litigation soon drew to a close when defendants reached back to a 1983 U.S. Supreme Court case that approved the use of an ERISA preemption defense in *Shaw v. Delta Airlines, Inc.*,<sup>53</sup> and in so doing, unleashed the proverbial floodgate of litigation that has entangled state law ever since.

#### Stage 2: The Schoolyard Bully – Broad "Relate to" Preemption Trumps State Law

By the early 1980's, managed care was becoming the common mode of financing and delivering health benefits especially given relentless cost inflation since HMOs tended to achieve at least initial cost savings when switching from fee-for-service plans.<sup>54</sup> Consistent with the 1973 HMO Act's directive that states could continue to regulate HMOs, states passed a variety of laws in response to managed care's growing market penetration.<sup>55</sup> For a time, it seemed that HMO beneficiaries would enjoy the same rights and protections accorded those who were conventionally insured. This quickly passed, though, once the innovative defense of ERISA section 514 "relate to" preemption protected the managed care industry from the reach of state regulators and individual litigants alike.

This truly seismic shift was triggered by U.S. Supreme Court cases that had nothing to do with health benefits. Basically, the Court accorded 514 preemption such a broad sweep that the statute seemed to displace almost any kind of state law. Interpreting section 514 in *Shaw v. Delta Airlines, Inc.*, the Court stated that a state law will "relate to" a plan and be preempted "if it has a connection with or reference to" an ERISA qualified

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53. 463 U.S. 85 (1983).

54. See Humphrey Taylor & Michael Kagay, *The HMO Report Card: A Closer Look*, 5 HEALTH AFFAIRS 81, 84-85 (1986).

55. See generally Fred J. Hellinger, *Any-Willing-Provider and Freedom-of-Choice Laws: An Economic Assessment*, 14 HEALTH AFFAIRS 297, 298 (1995).

benefit plan—as long as such claims were not “too tenuous.”<sup>56</sup> This broad and amorphous definition was soon invoked by a variety of defendants to evade all kinds of state laws on the ground that they had a “reference to” or were “connected with” an employee benefit plan.<sup>57</sup>

Thus, after over a decade of peaceful co-existence, ERISA now routinely preempted state laws simply because a benefits plan appeared somewhere in the case’s fact scenario.<sup>58</sup> This derailed state efforts to regulate a burgeoning managed care industry even though ERISA itself provided virtually no substantive regulation of employee health benefits. “The ERISA vacuum” of regulation grew as state efforts to regulate managed care through any willing provider,<sup>59</sup> or health care financing laws<sup>60</sup> fell to “relate to” preemption. Such successes led HMOs to assert preemption as a defense to almost any and all obligations imposed by state statutory or common law. Nowhere was this literally more painful than in cases where an injured patient (or his estate) attempted to hold an HMO liable for a decision affecting medical treatment. The seemingly straightforward application of existent tort principles to managed care that began in *Wickline* and *Wilson*,<sup>61</sup> had hit a dead end. Patients were left with no redress for harm resulting from an HMO’s denial of care, providers had limited ability to enforce reimbursement contracts, and states were severely restricted in addressing HMO practices or more generalized health care issues.

One of the earliest—and most troubling—examples of “relate to” preemption’s impact on patient care occurred in the 1992 case

56. *Shaw*, 463 U.S. at 96–97 (1983).

57. See, e.g., *id.* at 97–98 (1983) (“A law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan. Employing this definition, the [New York] Human Rights Law, which prohibits employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, which requires employers to pay employees specific benefits, clearly ‘relate to’ benefit plans.”) (footnotes omitted).

58. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52–54 (1986) (preemption of suits alleging improper claims processing).

59. See, e.g., *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 800 F. Supp. 328, 334–35 (E.D.Va. 1992), *vacated and remanded*, 995 F.2d 500, 505 (4th Cir. 1993) (District Court found that Virginia statute regarding HMO contracting with preferred provider organizations triggered “relate to” preemption since it regulated PPOs but did not qualify for saving clause protection. Appeals Court reversed, reasoning that the law did relate to a plan, but qualified as state insurance regulation saved from preemption); *Koch v. Mork Clinic*, 540 N.W.2d 526, 531 (Minn. Ct. App. 1995) (relate to preemption of state collateral source rule).

60. See, e.g., *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 721 (2d Cir. 1994), *rev’d sub nom* N.Y. State Conf. of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645, 668 (1995) (Court of Appeals found ERISA’s relate to clause preempted New York hospital surcharge statute due to economic impact on ERISA plans). For a discussion of the U.S. Supreme Court’s reversal, see *infra* at notes 88–108 and accompanying text.

61. See *supra* notes 48–52 and accompanying text.

of *Corcoran v. United HealthCare, Inc.*<sup>62</sup> Blue Cross served as third party administrator for a self-insured employee health benefits plan and contracted with United HealthCare (“UHC”) to administer the plan’s “Quality Care” or utilization review program.<sup>63</sup> UHC would assure delivery of “the most appropriate medical care” while eliminating “medically unnecessary treatment” along with the attendant financial costs and other risks of such treatment.<sup>64</sup>

Plaintiff’s obstetrician determined that the appropriate medical care for his patient, a woman in the third trimester of a high-risk pregnancy, was round-the-clock fetal monitoring in an acute care setting.<sup>65</sup> Only by providing monitoring under these circumstances, he reasoned, would it be possible to detect fetal distress and intervene immediately. UHC disagreed, but did approve 10 hours of at-home fetal monitoring by a visiting nurse. Despite the efforts of the physician and his patient to secure more comprehensive care, UHC would only approve coverage for a treatment protocol that not only deviated from the physician’s recommendation, but also defied common sense. Authorizing 10 hours of daily monitoring acknowledged the need for fetal monitoring. Yet, the protocol presumed that a fetus could somehow appreciate when it was being monitored, and confine any displays of distress to that period. Tragically, the fetus died while off-monitor.<sup>66</sup> The family brought a wrongful death action in state court against Blue Cross and UHC for UHC’s negligent medical decision to deny hospitalization and constant fetal monitoring.<sup>67</sup> They did not sue the obstetrician because he had vigorously advocated for inpatient care.<sup>68</sup>

The Fifth Circuit Court of Appeals found that UHC had made “a medical recommendation which—because of the financial ramifications—is more likely to be followed.”<sup>69</sup> However, since the allegedly negligent medical decision was part of “handling a benefit determination” it impermissibly related to a plan and thus was section 514 preempted.<sup>70</sup> This sad but, in the court’s view, unavoidable result was not altered by “the traditional or non-

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62. 965 F.2d 1321, 1322 (5th Cir. 1992).

63. *Id.* at 1323.

64. *Id.* (quoting plan documents).

65. *Id.* at 1322–23.

66. *Id.* at 1324.

67. *Id.*

68. *Id.* at 1324–25. Defendants asserted both section 514’s “relate to” preemption and diversity as grounds for removal. The court stated that a “relate to” preemption defense would have been independently sufficient to establish jurisdiction. *Id.* at 1325, n.4 (citing *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987)).

69. *Id.* at 1332.

70. *Id.*

traditional nature of the state law” involved<sup>71</sup> or the probability that Congress “could not have predicted” how ERISA preemption could affect utilization review decisions.<sup>72</sup> This effectively constructed a strong presumption *in favor* of preemption while denying plaintiffs any meaningful relief.

A year later, in the 1993 decision of *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*,<sup>73</sup> section 514 was found to preempt a medical malpractice challenge to a plan’s seven-month delay in approving payment for an employee beneficiary’s heart surgery. Although the plan ultimately reversed its initial denial of coverage, the patient’s health had so seriously declined by then that he was no longer a candidate for the procedure and he died. In the same year, *Spain v. Aetna Life Ins. Co.*,<sup>74</sup> reached a similar result when it held that ERISA’s broad “relate to” clause preempted a claim against an HMO for its refusal to approve a bone marrow transplant for a cancer patient. Now, *Corcoran’s* presumption in favor of broad “relate to” preemption was becoming an increasingly impermeable shield, rendering state tort liability essentially meaningless for patients who had been harmed by their HMO’s growing involvement in medical decision-making.

### Stage 3: Timeout – A Gradual Return to Traditional Preemption Analysis Intercepts ERISA’s Reach

In addition to eviscerating state tort law, preemption similarly derailed state regulatory efforts to rein in health care cost inflation and cross-subsidize uncompensated care. *Travelers Insurance Co. v. Cuomo*,<sup>75</sup> for example, struck down a New York hospital rate setting statute that required hospitals to impose a series of surcharges on the bills of patients who were covered by commercial payers.<sup>76</sup> Although the statute said nothing about ERISA benefit plans, it was successfully defeated on the ground that the statute impermissibly related to a plan by imposing indirect economic costs on it.<sup>77</sup> Faced with a similar challenge to a similar New Jersey law, though, the Third Circuit broke ranks in *United Wire, Metal, and Machine Health and Welfare Fund v. Morristown Memorial Hospital* when it found that such broad

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71. *Id.* at 1333–34.

72. *Id.* at 1334.

73. 999 F.2d 298, 303 (8th Cir. 1993).

74. 11 F.3d 129, 131 (9th Cir. 1993).

75. 14 F.3d 708, 723 (2d Cir. 1994), *rev’d sub nom* N.Y. Conf. Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). See *infra*, note 83 and accompanying text.

76. N.Y. PUB. HEALTH LAW 2807-C (McKinney 1993).

77. *Travelers Ins. Co.*, 14 F.3d at 718.



preemption violated ERISA's underlying intent.<sup>78</sup> It reasoned that a state law does not "relate to" a plan unless it specifically targets, or creates rights or restrictions predicated on the existence of such plans.<sup>79</sup> As conceptualized by the Third Circuit, a successful section 514 defense would need to show not only that the law had an effect on plans, but also that the effect created the type of interference with plan administration that Congress intended to preempt.

Since most courts continued to find broad "relate to" preemption, *United Wire* remained an outlier until 1995 when the U.S. Supreme Court granted certiorari<sup>80</sup> to resolve the conflict between the hospital rate setting rulings of the Second Circuit in *Travelers v. Cuomo*<sup>81</sup> and the Third Circuit in *United Wire*.<sup>82</sup> In ruling against preemption,<sup>83</sup> it could have adopted the *United Wire* test—that only laws that specifically target or predicate rights and restrictions on the existence of ERISA plans are "relate to" preempted.<sup>84</sup> Instead, it chose to return to a conventional preemption analysis in order to clarify what was becoming an increasingly confusing area of the law. Critiquing section 514's structural complexity and textual ambiguity<sup>85</sup> it also acknowledged that its past rulings had further complicated matters. Consequently, the Court found it necessary to spell out the mechanics of "relate to" analysis, beginning with "a starting presumption that Congress does not intend to supplant state law"<sup>86</sup> particularly in areas traditionally left to state control.<sup>87</sup>

The Court stated unequivocally that such laws are preempted only if it is "the clear and manifest purpose of Congress."<sup>88</sup> State laws that expressly reference an ERISA plan directly conflict with ERISA's text and thus are preempted by section 514.<sup>89</sup> In *Travelers*, though, there was no "reference" since the New York statute did not mention ERISA plans. To determine whether it had a

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78. 995 F.2d 1179, 1196 (3d Cir. 1993), reversing 793 F. Supp. 524, 542 (D.N.J. 1992).

79. *Id.* at 1192.

80. 513 U.S. 920 (1994).

81. 14 F.3d 708, 725 (2d Cir. 1994).

82. 995 F.2d 1179, 1196 (3d Cir. 1993).

83. 514 U.S. 645, 654 (1995). That the issue had great importance beyond these two cases was evidenced by the *amici curiae* briefs filed separately by a dozen states and the National Governor's Association in support of upholding the New York statute, along with a variety of large trade groups such as the Group Health Association of America, Inc. and the Federation of American Health Systems, which favored preempting it.

84. See *supra* note 78 and accompanying text.

85. It observed: "[i]f 'relate to' were taken to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for '[r]eally, universally, relations stop nowhere.'" 514 U.S. at 655.

86. *Id.* at 654–55 (citing *Maryland v. Louisiana*, 451 U.S. 725 (1981)).

87. *Blue Cross*, 514 U.S. at 655.

88. *Id.*

89. *Id.* at 656.

sufficient “connection” with ERISA plans, the Court needed to “go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”<sup>90</sup> That ERISA was intended to secure “nationally uniform administration of employee benefit plans” did not negate the presumption against preemption here because the rate setting law fell within the state’s traditional area of health care oversight.<sup>91</sup> What Congress did intend was to protect plan administrators from inconsistent and interfering state regulations, and thus must have intended “relate to” to displace those state laws which would overtly or effectively regulate actual plan administration. Accordingly, section 514 preempts laws that directly mandate or indirectly bind the choices of plan administrators or otherwise interfere with uniform plan administration.<sup>92</sup> The New York surcharge statute, however, only imposed an indirect economic cost on plans, which could affect—but would not bind—the plans’ “shopping decisions” concerning the administration and delivery of benefits.<sup>93</sup> The Court could find no evidence that “Congress chose to displace [such] general health care regulation, which historically has been a matter of local concern”<sup>94</sup> especially since such measures existed when ERISA was enacted.<sup>95</sup> As a result, the New York’s rate setting law would remain in effect.<sup>96</sup>

The Supreme Court’s more conventional and restrictive approach to “relate to” preemption continued in *California Division of Labor Standards Enforcement v. Dillingham*, where it rejected ERISA preemption of a state labor law, and again emphasized that courts must presume that Congress would not override state police powers absent clear evidence of an intent to do so.<sup>97</sup> In *DeBuono v. NYSA-ILA Medical & Clinical Service Fund*<sup>98</sup> where it found that a state tax on both ERISA-funded and non-ERISA funded health care providers was simply “one of ‘a myriad state laws’ of general applicability that impose[d] some burdens on the administration of ERISA plans but nevertheless [did] not ‘relate to’ them within the meaning of the statute.”<sup>99</sup> For a short time, the *Travelers-Dillingham-DeBuono* trilogy encouraged state legislators,

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90. *Id.*

91. *Id.* at 657.

92. *Id.* at 658–59.

93. *Id.* at 660.

94. *Id.* at 661 (citations omitted).

95. *Id.* at 665.

96. *Id.* at 668.

97. 519 U.S. 316, 325 (1997).

98. 520 U.S. 806, 816 (1997).

99. *Id.* at 815.

providers, and patients to believe that: (1) courts were now better equipped to resolve “relate to” preemption challenges with consistency and predictability; and (2) managed care organizations could no longer use section 514 to evade their responsibilities under state law. But it was only for a short time.

Stage 4: [Complete vs. Conflict Preemption] + [Quality vs. Quantity] = Dazed & Confused

The plaintiff’s bar enthusiastically embraced *Travelers*, believing that negligence claims for medical decision making would now survive preemption since common law negligence is even more traditionally “state” than hospital rate setting statutes. However, *Travelers*’ apparent restriction of section 514 “conflict” preemption regarding state oversight of “quality” catalyzed a shift to section 502 “complete” preemption of a plan’s “quantity” or coverage determinations. It soon became apparent that the Supreme Court’s attempt to forge a clear path through the minefield of section 514 preemption ironically had only made things worse.

The confusion began a month later when the Third Circuit rejected section 502 complete preemption of medical decision making claims in *Dukes v. United States Healthcare, Inc.*<sup>100</sup> Previously, removing state tort claims to federal court on section 514 conflict preemption grounds happened routinely.<sup>101</sup> The federal district court typically dismissed the removed claims as section 514 preempted because “the treatment received must be measured against the benefit plan” and, for an ERISA plan, such claims necessarily related to that plan.<sup>102</sup> Once again, though, the Third Circuit saw things quite differently, this time by finding no section 514 removal jurisdiction.

To remove a state claim to federal court, the defendant bears the burden of establishing federal jurisdiction.<sup>103</sup> Under the “well-pleaded complaint rule,” the federal district court should confine itself to the face of the complaint in determining whether federal

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100. 57 F.3d 350 (3d Cir. 1995). The decision overruled the consolidated cases of *Dukes v. U.S. Health Care Sys. Inc.*, 848 F. Supp. 39 (E.D. Pa. 1994) which had asserted a wrongful death case against an HMO for its failure to perform certain blood tests, and *Visconti v. U.S. Health Care Sys., Inc.*, 857 F. Supp. 1097 (E.D. Pa. 1994) which concerned direct and vicarious liability claims for negligence in selecting providers and delivering care.

101. See, e.g., *Corcoran*, 965 F.2d at 1331 (discussed *supra* note 62); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D.N.Y. 1994).

102. *Dukes*, 57 F.3d at 351. Remaining claims were then remanded to state court. *Dukes*, 848 F. Supp. at 42.

103. See 28 U.S.C. §§ 1441(a), 1446(a). The U.S. Supreme Court has long held that removal statutes do not create independent grounds for federal jurisdiction and should be strictly construed. See *Shamrock Oil & Gas Corp. v. Sheets*, 313 U.S. 100, 108–09 (1941).

jurisdiction exists.<sup>104</sup> A state claim normally will not support federal jurisdiction unless Congress intended federal law to supplant it. Such instances of “complete” preemption—which include ERISA’s section 502—create federal question jurisdiction and allow removal from state to federal court.<sup>105</sup> Before *Dukes*, HMOs had routinely used section 514 to remove state cases to federal courts,<sup>106</sup> but now, the Third Circuit reasoned that section 514’s “relate to” clause involved conflict rather than complete preemption and thus did not confer federal question jurisdiction. Complete preemption under section 502’s civil enforcement provisions would have supported removal had plaintiffs complained of improper withholding or processing of plan benefits.<sup>107</sup> A section 514 conflict preemption defense to a state law claim would not create federal jurisdiction because state courts are just as qualified as their federal counterparts to resolve conflict preemption disputes.

The case could have ended there, but the Third Circuit went on in dicta to untangle the “quality” and “quantity” components of managed care decisions despite the Fifth Circuit’s belief in *Corcoran* that the two were inseparable. Rather than criticize *Corcoran* for improperly finding “relate to” preemption of an essentially medical and, therefore, quality decision,<sup>108</sup> the *Dukes* court stated that contesting the prospective utilization review in *Corcoran* amounted to a completely preempted challenge to a section 502 benefits determination. In contrast, *Dukes* involved claims of negligent provision of care, not improper claims processing or benefits determinations. This distinction was a bit too facile since even *Corcoran* conceded that the HMO decisions being challenged were medical ones.<sup>109</sup> Nevertheless, the *Dukes* court concluded that a preemption challenge to the medical claims before it could only be grounded in section 514’s “relate to” clause and, therefore, belonged in state court absent independent grounds for federal jurisdiction.

Coming so soon after *Travelers’* renewed regard for state oversight of health care quality issues, *Dukes’* bright line distinctions between section 514 vs. section 502 preemption, and

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104. See *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 9–10 (1983).

105. See *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63–64 (1987).

106. See, e.g., *Corcoran*, discussed *supra* note 62 and accompanying text.

107. In that instance, equitable relief under § 502(a) to recover benefits, enforce rights, or clarify future rights under the terms of the plan would still be available after exhausting administrative remedies under the plan (even though equitable or declaratory relief is often futile post-injury). See 29 U.S.C. § 1132(a); *Turner v. Fallon Comty. Health Plan, Inc.*, 127 F.3d 196, 198 (1st Cir. 1997); *Belanger v. Healthsource of Me.*, 66 F. Supp. 2d 70, 73 (D. Me. 1999).

108. See *infra* note 62 and accompanying text.

109. Compare discussion of *Corcoran*’s treatment of medical decision making, *supra* note 62 and accompanying text.

“quality” vs. “quantity,” had a huge and immediate impact on ERISA jurisprudence.<sup>110</sup> In theory, the courts seemed poised to retreat from *Corcoran* and return to the early *Wickline* days when a UR decision to override or delay care might be actionable under state negligence law.<sup>111</sup> In reality, the *Travelers’* and *Dukes’* efforts at analytical clarity unleashed a deluge of inconsistent opinions as the bright line devolved to a blur.

An early example was *Jass v. Prudential Health Care Plan, Inc.* in which both section 502 and section 514 blocked claims against an HMO and its UR nurse for failing to authorize physical therapy following knee surgery.<sup>112</sup> Because the nurse was administering the plan, section 502 completely preempted the negligence claim against her as well as the vicarious liability claim against the HMO for her UR decision.<sup>113</sup> In the court’s view:

[T]he preemptive force of ERISA is so powerful that it converts “a state law claim into an action arising under federal law,”<sup>114</sup> even if the plaintiff does not want relief under ERISA. [citation omitted] This is true even though the same facts might be sufficient to state a state law cause of action for negligence.<sup>115</sup>

In addition, section 514 preempted vicarious liability claims against the HMO for the treating physician’s negligent treatment because, in actuality, the claims were rooted in the failure to treat due to the plan’s denial of benefits.<sup>116</sup> Consequently, plaintiff would have to look to section 502 for equitable relief even if it offered too little too late.<sup>117</sup>

At this time, *Dukes* still seemed to be on solid ground since, having decided the *Travelers-Dillingham-DeBuono* trilogy, the Supreme Court’s 1997 decision in *Boggs v. Boggs* continued to underscore its return to traditional preemption analysis—and attendant respect for the preeminence of state law in certain contexts.<sup>118</sup> While not a health benefits case, the 5-4 *Boggs* decision is notable since both the majority and dissent reduced a potentially complex “relate to” challenge of a Louisiana testamentary transfer statute<sup>119</sup> to a simple inquiry into whether

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110. 57 F.3d at 361.

111. See *supra* notes 48–52 and accompanying text.

112. 88 F.3d 1482 (7th Cir. 1996).

113. *Id.* at 1485.

114. *Id.* at 1490 (quoting *Metro. Life Insur. Co. v. Taylor*, 481 U.S. 58, 64 (1987)).

115. *Id.* (citing *Metro. Life Ins. Co.*, 481 U.S. at 66–67).

116. *Id.* at 1493–94.

117. *Id.* at 1495.

118. 520 U.S. 833 (1997).

119. LA CIV. CODE ANN. art. 535 (2008). The law permitted a non-plan participating spouse to make a testamentary transfer of her interest in her husband’s undistributed pension plan benefits.

Congress intended ERISA to supplant this type of state law. The majority found section 514 preemption due to a “direct clash” between ERISA and the Louisiana provision.<sup>120</sup> Maintaining *Travelers’* focus on congressional intent, the dissent found no preemption given no evidence that Congress intended to preempt the traditionally state-regulated issues of domestic relations and community property law that were at the core of the case.<sup>121</sup>

Notwithstanding the Supreme Court’s seemingly restrictive view of preemption, the lower courts continued to struggle – and differ – in distinguishing quality from quantity and section 502 from section 514 in *Turner v. Fallon Community Health Plan, Inc.*<sup>122</sup> and *Bast v. Prudential Insurance Company of America*.<sup>123</sup> Each case sought damages for the death of a spouse allegedly caused by the plan’s refusal to approve an autologous bone marrow transplant. Denial of coverage was based on the plan-wide package of benefits – what *Dukes* would characterize as administrative determinations regarding the “quantum of benefits” – rather than denying or delaying a covered benefit for a particular patient as occurred in *Dukes* and *Corcoran*. *Turner* and *Bast* agreed that ERISA preempted plaintiffs’ claims, but differed as to why and how. In *Turner*, the First Circuit found that section 502 completely preempted damage claims because the plan documents excluded the treatment as unproven for solid tumors. Accordingly, relief could only be obtained through section 502 even though its focus on equitable relief provided no meaningful remedies.<sup>124</sup> In *Bast*, the Ninth Circuit also found preemption – but this time under section 514’s “relate to” clause.<sup>125</sup> Even though purely equitable relief has little meaning after a patient’s death, the court also rejected plaintiff’s argument that damages should be available under section 502’s civil enforcement remedies.<sup>126</sup>

At the same time, a completely different result obtained in *Pappas v. Asbel*<sup>127</sup> when the Pennsylvania Supreme Court denied

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A man’s first wife predeceased him and bequeathed her interest to her sons. He remarried and, upon his death, his new wife claimed his retirement benefits. The sons from his first marriage contested this, claiming that those benefits were theirs by virtue of their mother’s prior testamentary transfer under the Louisiana statute. The second wife argued that section 514 preempted the law and a 5-4 majority agreed. *Boggs*, 520 U.S. at 854.

120. *Id.*

121. *Id.* at 873–74. The Court’s fealty to *Travelers* was again demonstrated in *Unum Life Insurance Company of America v. Ward*, 526 U.S. 358, 375–76 (1999), which unanimously ruled that California’s notice-prejudice rule was saved from ERISA preemption despite conflicting with ERISA’s substantive provisions since disuniformities are the inevitable result of Congress’ intent to save insurance regulation from relate to preemption.

122. 127 F.3d 196 (1st Cir. 1997).

123. 150 F.3d 1003 (9th Cir. 1998).

124. 127 F.3d at 199.

125. 150 F.3d at 1008.

126. *Id.* at 1010.

127. 724 A.2d 889 (Pa. 1998).

preemption of a state medical malpractice challenge to an HMO's delay in authorizing an emergency hospital transfer.<sup>128</sup> The trial court had found section 514 preemption since the transfer delay was an administrative decision.<sup>129</sup> The intermediate appeals court reversed, explaining that negligence law is a form of state oversight in matters of health quality<sup>130</sup> which, at most, has only an indirect economic impact that survives preemption under *Travelers*.<sup>131</sup> The state supreme court affirmed, reasoning that the transfer delay was "indisputably [] intertwined with the provision of safe medical care" and Congress never intended "to preempt state laws concerning the regulation of the provision of safe medical care."<sup>132</sup> It nevertheless recognized the quantity implications of denying transfer to a particular hospital, acknowledging "there will be a financial impact on HMOs. Yet, that is not enough to countermand the conclusion that these claims are not preempted."<sup>133</sup> For the *Pappas* court, the enmeshed quality and administrative aspects of a plaintiff's claim were not enough to warrant section 514 preemption, although many courts had already disagreed.

Cases such as *Turner*, *Bast*, and *Pappas* showed just how important judicial characterization of a claim had become to the ultimate resolution of an ERISA preemption challenge. Increasingly, surviving complete and/or conflict preemption now required winning the battle of semantics. This reflected the deeper problem of expecting black and white labels to capture so many shades of gray. Despite its conceptual appeal, the *Dukes* approach of bifurcating "quality" from "quantity," and "medical" from "administrative" decisions is often too difficult to implement in a given fact scenario.<sup>134</sup>

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128. After receiving steroid injections for neck and shoulder pain from his internist, Mr. Pappas experienced numbness in his chest, abdomen, and limbs and could not walk. At the community hospital ER, Dr. Asbel detected a cervical epidural abscess compressing the spinal cord which warranted immediate transfer to Jefferson Hospital's spinal cord trauma unit. The HMO denied authorization for a transfer to Jefferson, but approved transfer to three other hospitals. Dr. Asbel and the community hospital's neurosurgeon made several requests to speak with the HMO physician, but they were only permitted to speak with the HMO's administrative personnel. Mr. Pappas was ultimately transported to the Medical College of Pennsylvania Hospital, but he became paralyzed. In addition to malpractice claims against Asbel and the community hospital, Pappas sued his HMO, claiming that "negligence in causing an inordinate delay in transferring him to a facility equipped and immediately able to address the neurological emergency" exacerbated the spinal compression, and resulted in quadriplegia. 675 A.2d 711, 713-14 (Pa. Super. Ct. 1996).

129. *Id.*

130. *Id.* at 169 (citing *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 833 (1988)).

131. *Id.* at 171-72.

132. *Pappas*, 724 A.2d at 893.

133. *Id.* at 894. In addition, disputing the lower court's contention that Congress could not have intended ERISA to preempt challenges to HMO cost-containment, it observed that enacting the Federal HMO Act just one year before ERISA showed that Congress did indeed understand managed care. *Id.* at 893.

134. See, e.g., *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003) (state tort claim based on mixed eligibility

The limits of *Dukes's* quality versus quantity and section 502 versus section 514 distinctions are highlighted in *Danca v. Private Health Care Systems, Inc.* involving pre-certification of psychiatric hospitalization, but denial of the particular hospital and program requested.<sup>135</sup> After being treated at the approved hospital, the plaintiff patient was released, attempted suicide by drug overdose, was re-hospitalized at another facility, and again attempted suicide—this time by self-immolation which disfigured over 45% of her body and destroyed the fingers on both hands.<sup>136</sup> The case was removed to federal district court where plaintiff argued that her negligent pre-certification claim went to the quality of benefits delivered since treatment was not denied outright; defendants countered that choosing a specific hospital was precisely the kind of administrative decision that Congress intended to protect through preemption.<sup>137</sup> The district court found section 514 preemption because challenging a benefits determination impermissibly relates to plan administration.<sup>138</sup> The First Circuit preempted under both section 502 and section 514. In its view, “quasi-medical” UR decisions are “indisputably” part of benefits determinations,<sup>139</sup> making a negligence challenge a section 502 preempted alternative enforcement mechanism and a section 514 conflicting state law.<sup>140</sup>

In contrast to *Danca's* refusal to recognize HMO negligence, the Third Circuit in *Bauman v. U.S. Healthcare* permitted a negligence challenge to a plan's maternity length of stay policy since it affected quality of care.<sup>141</sup> It explained that, independent of its administrative tasks (such as accounting and record

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decisions not completely preempted).

135. 185 F.3d 1 (1st Cir. 1999). The plaintiff had a long history of mental illness, was acutely psychotic, and her physician recommended that she be admitted to McLean Hospital where she had been treated successfully in the past. The utilization reviewer denied this request and pre-certified her for Emerson Hospital, which did not offer the particular therapy available at McLean. *Id.* at 3.

136. *Id.* at 2–4. See also *Danca v. Emerson Hosp.*, 9 F. Supp. 2d 27, 32 (D. Mass. 1998).

137. *Danca*, 9 F. Supp. 2d at 31–32.

138. *Id.* The federal district judge urged patients to be more proactive in invoking section 502's civil enforcement provisions if initially displeased with a plan's refusal to comply with the treating physician's determination of medical necessity. In doing so, the judge showed little appreciation for the logistical difficulties of, and disincentives to mounting a legal challenge in the midst of an urgent medical situation where the law itself poses little likelihood of success given its limitation of remedies and standard of judicial deference to plan decisions.

139. *Danca*, 185 F.3d at 5–6 (citations omitted).

140. *Id.* at 17. Further examples of an HMO's individual treatment decisions triggering either section 502 and/or section 514 preemption are numerous and include *Tolton v. America Bodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (section 514 preemption of state claims based on HMO's denial of inpatient care to suicidal patient); *Lancaster v. Kaiser Foundation Health Plan*, 958 F. Supp. 1137 (E.D. Va. 1997) (section 502 preemption of negligence claims regarding referrals and testing).

141. 193 F.3d at 156–57. Future U.S. Supreme Court Justice Samuel Alito concurred in the *Lancaster* court's reflection that the “most significant contribution” of its prior decision in *Dukes* was its distinction between the quality and quantum of benefits. *Id.* at 161–62 (citing *Dukes*, 57 F.3d at 357–58).



keeping),<sup>142</sup> a plan acts as a “a health care provider” in arranging and delivering medical treatment “directly or through contracts with hospitals, doctors, or nurses.”<sup>143</sup> Thus, section 502 completely preempts claims that seek to enforce or clarify benefits due, but not “state-law claims directed to the quality of benefits provided.”<sup>144</sup> Challenging the quality of care instead of the quantum of benefits rested on “the HMO’s essentially medical determination of the appropriate level of care”<sup>145</sup> and therefore survived section 502 complete preemption.<sup>146</sup>

Patients were not just concerned about managed care’s quasi-medical role in authorizing care; they also challenged the use of financial decisions to influence provider decisions regarding diagnostic testing, treatment, and referrals. These were harder cases since financial incentives were at least facially the kind of administrative decision protected by preemption. Yet, some courts found that even these can survive complete and conflict preemption when sufficiently integrated with the quality of care provided. In *Stewart v. Berry Family Health Center*,<sup>147</sup> for example, section 502 did not completely preempt a claim that the HMO’s “financial incentives and cost control systems were the direct and proximate cause” of inadequate diagnosis and treatment.<sup>148</sup> The court stated that the claim’s “proper characterization . . . is highly important”<sup>149</sup> because section 502 does not preempt a claim for wrongful denial of benefits.<sup>150</sup> Instead, financial incentives that allegedly “affected the standard of care,”<sup>151</sup> are “more properly characterized as challenging a [non-section 502 preempted] medical decision to deny proper treatment to a patient rather than an administrative decision to deny benefits.”<sup>152</sup> Plus, there was no section 514 “relate to” preemption as the HMO-provider

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142. “As an administrator overseeing an ERISA plan, an HMO will have administrative responsibilities over the elements of the plan, including determining eligibility for benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records. As we held in *Dukes*, claims that fall within the essence of the administrator’s activities in this regard fall within section 502(a)(1)(B) and are completely preempted.” *Id.* at 162.

143. *Id.* (citing both *Dukes*, 57 F.3d at 361, and *Corcoran*, 965 F.2d at 1329–34, for the point that HMOs act as both health care providers and plan administrators).

144. *Id.* at 161–62 (citing *Dukes*, 57 F.3d at 356).

145. *Id.* at 163.

146. *Id.* at 164; accord *Crum v. Health-Alliance Midwest, Inc.*, 47 F. Supp. 2d 1013, 1016 (C.D. Ill. 1999) (plan’s policy of requiring pre-approval from an advisory nurse before using the emergency room was sufficiently medical in nature to constitute the kind of quality claim that survives preemption). See also *Napoletano v. Cigna Healthcare*, 680 A.2d 127 (Conn. 1996); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994).

147. 105 F. Supp. 2d 807 (S.D. Ohio 2000).

148. *Id.* at 811.

149. *Id.* at 812.

150. *Id.* at 815.

151. *Id.* at 813.

152. *Id.* at 815.

relationship “does not rest upon the terms of the plan . . . .”<sup>153</sup>

That patients prevailed in *Stewart, Pappas* and the Third Circuit’s cases only compounded the unpredictability of deciding whether and how to litigate these claims. In other jurisdictions, most patients lost and increasingly did because of section 502. There had to be a better way to enforce patients’ rights if ERISA was going to render so many kinds of state laws inoperative. And in Stage Five, the plaintiffs’ bar was about to look for it by reasoning that, if ERISA truly supplanted all state claims, then ERISA’s own civil enforcement scheme must provide some sort of redress to those injured by an HMO’s decision. Although this tactic ultimately failed, it launched a renewed respect for state law. But this too, did not last long.

#### Stage 5: Offense as Defense – Seeking ERISA Remedies as an End-Run Around Preemption.

Since HMOs had enjoyed so much success in using complete and conflict preemption to avoid state jurisdiction and evade liability under state common and statutory law, patients decided to look to ERISA itself for relief. One strategy was to focus on an HMO’s use of financial incentives and UR practices to reduce treatments and referrals. The U.S. Supreme Court appeared to light the way in its 1996 holding in *Varity Corp. v. Howe*<sup>154</sup> that breach of fiduciary obligation claims are actionable under section 502(a)(3)’s provision for “other equitable relief,” and its 1999 decision in *Humana Inc. v. Forsyth*<sup>155</sup> that RICO<sup>156</sup> actions could be brought against insurance companies. At the same time, a well-organized group of plaintiffs’ attorneys were winding down their lucrative state Medicaid reimbursement litigation against the tobacco industry. Flush with cash and primed with experience in using class-action litigation to circumvent evidentiary problems of individual causation, they turned their attention and resources to holding HMOs accountable for patient harms.<sup>157</sup>

The self-described “REPAIR” team<sup>158</sup> and like-minded litigants asserted a variety of claims, including RICO violations and breach of ERISA fiduciary obligations, based on the HMOs’ inadequate disclosure of the impact of financial incentives and other cost control techniques on the delivery of quality health care. RICO’s

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153. *Id.*

154. 516 U.S. 489 (1996).

155. 525 U.S. 299, 311 (1999).

156. Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961 et seq. (2006).

157. See, e.g., Laurie McGinley & Milo Geyelin, *Attorneys Prepare Suits Against HMOs*, WALL ST. J., Sept. 30, 1999, at A3.

158. *Id.*

promise as an alternative basis for relief was short-lived when *Maio v. Aetna, Inc.* rejected claims that Aetna violated RICO by fraudulently advertising its commitment to quality health care when it was instead devoted to fiscal constraints.<sup>159</sup> Aetna's quality assurance advertisements were deemed obvious puffery that could not support a fraud count.<sup>160</sup> Plus, any injury was "too hypothetical" and unsupported by a showing of proximate cause.<sup>161</sup>

Claiming breach of ERISA disclosure obligations produced mixed results. *Drolet v. Healthsource* recognized an ERISA-imposed fiduciary obligation to inform patients of physicians' financial incentives to contain treatment and referrals in denying defendant's motion to dismiss.<sup>162</sup> In *Shea v. Esenstein*, the Eighth Circuit recognized a similar duty resulting in the settlement of several claims.<sup>163</sup> In contrast, *Weiss v. CIGNA Healthcare, Inc.* found no ERISA fiduciary obligation to disclose financial incentives.<sup>164</sup>

*Weiss* foreshadowed the U.S. Supreme Court's 2000 death knell to using section 502 remedies to circumvent preemption problems in *Pegram v. Herdrich*.<sup>165</sup> There, the patient claimed that her physician-owned HMO's financial incentive plan induced physicians to provide less care than medically necessary in breach of ERISA's fiduciary obligations—in this case, a delayed ultrasound that led to a ruptured appendix.<sup>166</sup> Thus, the *Pegram* Court had to decide whether treatment decisions made by an HMO acting through its treating physicians are fiduciary acts under ERISA.<sup>167</sup> Ruling that such "mixed treatment and eligibility decisions"<sup>168</sup> are not fiduciary in nature,<sup>169</sup> it effectively found that ERISA itself would continue to provide little help in filling the gap caused by sections 502 and 514 preemption of state remedies.

Writing for a unanimous court, Justice Souter acknowledged

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159. No. 99-1969, 1999 U.S. Dist. LEXIS 15056, at \*8 (E.D. Pa. Sept. 29, 1999).

160. *Id.*

161. *Id.* at \*7.

162. 968 F. Supp. 757, 760 (D.N.H. 1997).

163. 107 F.3d 625, 628 (8th Cir. 1997).

164. 972 F. Supp. 748, 754 (S.D.N.Y. 1997).

165. 530 U.S. 211 (2000).

166. Mrs. Herdrich sought treatment from Lori Pegram, M.D., a Carle physician, for abdominal pain. She was sent home and returned six days later with a palpable inflamed mass in her abdomen. Rather than arrange for an immediate ultrasound examination at a local hospital, Dr. Pegram scheduled her patient for an ultrasound at a facility staffed by Carle even though it would entail a one-week delay and fifty mile trip. Before that ultrasound was administered, Mrs. Herdrich's appendix ruptured, causing acute peritonitis and a week-long stay in the hospital. At trial, ERISA's preemption of her state fraud count led her to reframe her claim under ERISA's fiduciary requirements. *Id.* at 215-16.

167. *Id.* at 219.

168. *Id.* at 229.

169. *Id.* at 237.

that under both fee-for-service medicine and managed care, physicians face financial incentives that influence their treatment decisions.<sup>170</sup> An “inducement to ration”<sup>171</sup> is an inevitable feature of any risk-bearing managed care plan but only the legislature, not the courts, can make the complex policy choices in setting appropriate tradeoff levels of risks and costs.<sup>172</sup> Further, ERISA does not support a claim for breach of fiduciary duty against an HMO acting through its treating physicians where the physician’s “eligibility decision and the treatment decision were inextricably mixed, as they are in countless medical administrative decisions every day.”<sup>173</sup>

The *Pegram* Court clarified that, under ERISA, an HMO is not an employee welfare benefit plan; rather, the plan is embodied by the agreement between the HMO and the employer by which the employer agrees to pay premiums and the parties establish “rules under which beneficiaries will be entitled to care.”<sup>174</sup> Under ERISA, an HMO can only breach a fiduciary duty if acting as a plan fiduciary.<sup>175</sup> Consequently, financial incentives that place a physician’s economic self-interest in reducing care at odds with his patient’s need for services do not necessarily constitute a breach of fiduciary responsibilities under ERISA.

An HMO can make: 1) “pure eligibility decisions turn[ing] on the plan’s coverage of a particular condition or medical procedure for its treatment;”<sup>176</sup> or 2) pure treatment decisions, entailing choices about the appropriate medical response in terms of diagnosis and treatment “given a patient’s constellation of symptoms . . . .”<sup>177</sup> However, the Court emphasized that HMOs can wear two hats at a time with different categories of decisions becoming “practically inextricable from one another”<sup>178</sup> forming a third category of mixed eligibility and treatment decisions. In the

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170. *Id.* at 219. The Court noted that managed care’s cost control techniques evolved in direct response to the fee-for-service incentive and stated that the check on any system of financial incentives is “the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient’s interest.” *Id.* (citing Brief for American Medical Association as amicus curiae 17–21).

171. *Id.* at 221.

172. *Id.*

173. *Id.* at 229.

174. *Id.* at 223. An ERISA fiduciary “must be someone acting in the capacity of manager, administrator, or financial adviser” to such a plan. *Id.* at 222. An HMO can become an ERISA fiduciary if it administers the plan, i.e., the agreement between the employer and the HMO to finance and deliver health benefits to employee plan participants and their beneficiaries. *Id.* at 223.

175. *Id.* at 226 (observing that since ERISA does not dictate the creation or design of benefits plans, an employer’s decisions about either “are not themselves fiduciary acts”) (citing *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) (“Nothing in ERISA requires employers to establish employee benefit plans. Nor does ERISA mandate what kind of benefit employers must provide if they choose to have such a plan.”)).

176. *Id.* at 228.

177. *Id.*

178. *Id.*

Court's view, pure eligibility decisions involve "fiduciary administrative functions" that Congress intended to be subject to section 502 civil enforcement provisions for breach of fiduciary obligation.<sup>179</sup> In contrast, pure treatment decisions as well as mixed eligibility and treatment decisions resemble typical physician treatment decisions. The Court doubted that Congress intended these to be actionable as fiduciary claims, especially given Congress's preoccupation with pension plan funding and mismanagement when it enacted ERISA.<sup>180</sup>

Uncertainty regarding Congress's preemptive intent should have been enough to resolve the issue given the strong presumption against preemption demanded by *Travelers*.<sup>181</sup> Here, however, any doubt regarding Congress' intent to exclude mixed decisions from administrative fiduciary ones "hardens into conviction" because an ERISA claim for breach of fiduciary duties would merely duplicate "the law already available in state courts and federal diversity actions today . . . ."<sup>182</sup> As a result, an HMO's mixed eligibility and treatment decision cannot be challenged under ERISA as a breach of fiduciary obligation.<sup>183</sup>

As a straightforward request for section 502 remedies, *Pegram* was not a preemption case *per se* although it occurred because sections 502 and 514 had preempted so many state remedies despite *Travelers*' return to traditional preemption analysis.<sup>184</sup> While *Pegram* ruled for the HMO, its rationale held great promise for patients since reading it together with the *Travelers* trilogy and *Boggs* suggested that mixed treatment-eligibility decisions should be actionable under state tort law.<sup>185</sup> However, any such hope for plaintiffs was dashed by *Rush Prudential HMO, Inc. v. Moran*,

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179. *Id.* at 232.

180. *Id.* (citing S. REP. NO. 93-127, 5 (1973); S. REP. NO. 93-383, 17 (1973)).

181. *See supra* note 97 and accompanying text.

182. *Id.* at 232.

183. *Id.* at 237. The *Pegram* Court concluded its opinion with a stinging attack on plaintiff, finding that this was actually a much easier call than *Travelers*:

To be sure, [*Travelers*] throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose. But in that case the convergence of state and federal law was not so clear as in the situation we are positing; the state-law standard had not been subsumed by the standard to be applied under ERISA. We could struggle with this problem, but first it is well to ask, again, what would be gained by opening the federal courthouse doors for a fiduciary malpractice claim, save for possibly random fortuities such as more favorable scheduling, or the ancillary opportunity to seek attorney's fees. And again, we know that Congress had no such haphazard boons in prospect when it defined the ERISA fiduciary, nor such a risk to the efficiency of federal courts as a new fiduciary malpractice jurisdiction would pose in welcoming such unheard-of fiduciary litigation.

*Pegram v. Herdrich*, 530 U.S. 211, 237 (2000).

184. *See supra* note 165 and accompanying text.

185. *See supra* notes 83-98, 118 and accompanying text.

which actually found for the patient but incentivized plans to self insure in order to evade state liability.<sup>186</sup> And in 2004's *Aetna Health Inc. v. Davila*,<sup>187</sup> Pegram's early patient-protective implications evaporated entirely, leaving both patients and state legislators with a severe case of judicial vertigo.

*Rush Prudential v. Moran* involved Illinois' statutory requirement of external review for managed care coverage denials based on medical necessity determinations.<sup>188</sup> As he had in *Pegram*, Justice Souter wrote for the majority, and explained that although the additional layer of review related to employee benefit plans,<sup>189</sup> it was saved from section 514 preemption as a state insurance measure.<sup>190</sup> The defense argued that HMOs are health care providers, not insurers,<sup>191</sup> but the Court disagreed, describing an HMO as "both: it provides health care, and it does so as an insurer."<sup>192</sup> Further, the federal 1973 HMO Act's text and legislative history showed that Congress has always conceptualized HMOs as performing the essential insurance functions of spreading and bearing risk.<sup>193</sup> Ensuing changes in managed care products and risk transfer methods will not prevent states from regulating HMOs in their traditional oversight of the insurance industry.<sup>194</sup> The Court also clarified that since the three McCarron-Ferguson criteria used to determine savings clause protection<sup>195</sup> were only "guideposts," a state law could be saved without satisfying all of them.<sup>196</sup> The Illinois law met at least two.<sup>197</sup>

The HMO countered that even if saved under section 514, the law could still be completely preempted by section 502 for disrupting ERISA's goal of uniformity and creating enforcement mechanisms not included in section 502's civil remedies scheme.<sup>198</sup>

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186. 536 U.S. 355 (2002).

187. 542 U.S. 200 (2004); see *infra* note 21027 and accompanying text.

188. 536 U.S. at 362 (addressing the Health Maintenance Organization Act, 215 ILL. COMP. STAT., 125, §§ 4-10 (2000)). Having obtained a favorable external review, plaintiff sued her HMO to reimburse her for the previously denied \$95,000 microneurolysis surgery.).

189. *Id.* at 365.

190. *Id.* at 373.

191. *Id.* at 366.

192. *Id.* at 367.

193. *Id.* at 368 (citing Health Maintenance Organization Act of 1973 § 1301(c), 87 Stat. 916, codified as amended at 42 U.S.C. § 300e(c) (1994); S. REP. NO. 93-129, at 14 (1973)).

194. *Id.* at 370-371. That today HMOs typically try to shift risk to the provider through capitation or other means did not dissuade the Court from this result. *Id.* at 372-73 (observing "that HMOs are not traditional 'indemnity' insurers is no matter; we would not undertake to freeze the concepts of 'insurance' . . . into the mold they fitted when these Federal Acts were passed[.]" (quoting *SEC v. Variable Annuity Life Ins. Co. of Am.*, 359 U.S. 65, 71 (1959)).

195. *Id.* at 373.

196. *Id.*

197. *Id.* at 373-75.

198. *Id.* at 385-87.

This argument failed since the external review requirement applied to the HMO – not the plan contracting with the HMO – and created the kind of indirect economic costs permitted by *Travelers*.<sup>199</sup> Therefore, given no clear indicia of Congress' preemptive intent, the state statute survived both section 514 and section 502 preemption.<sup>200</sup> Writing for the four dissenters, Justice Thomas stated that *Travelers*, a section 514 case, should not impede section 502 preemption from ensuring the "exclusivity and uniformity of ERISA's enforcement scheme[.]"<sup>201</sup> Here, section 502 should preempt the Illinois measure because it created a "separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."<sup>202</sup> Still, *Rush* was a clear "win" for patients and states, even though it incentivized plans to self-insure in order to avoid section 514's "saved" state insurance regulation.

For a short while, it looked as if the Supreme Court might stay the restrictive preemption course regarding managed care when it unanimously found Kentucky's any-willing-provider law to be saved from section 514's "relate to" preemption in *Kentucky Ass'n. of Health Plans v. Miller*.<sup>203</sup> Since the 1985 case of *Metropolitan Life Insur. Co. v. Massachusetts*,<sup>204</sup> the McCarron-Ferguson Act's three-part test for defining insurance had dictated the limits of section 514's savings clause protection for state insurance regulation. In *Rush Prudential*, the Court had downgraded the requirements to "guideposts."<sup>205</sup> Now, it acknowledged that importing McCarron-Ferguson criteria into ERISA law had "misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis."<sup>206</sup> For this reason, it announced a "clean break," and stated that to be saved from section 514's "relate to" preemption, a state law "must be specifically directed toward entities engaged in insurance [and] must substantially affect the risk pooling arrangement between the insurer and the insured."<sup>207</sup> The Kentucky statute did both and therefore was saved because it (1) targeted HMOs which, at least in certain respects, act as insurers; and (2) affected risk pooling by effectively precluding HMOs from using closed networks in exchange for lower premiums.<sup>208</sup>

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199. *Id.* at 381, n.11.

200. *Id.* at 387 (citing *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 741 (1985)).

201. *Id.* at 393-94 (Thomas, J. dissenting)

202. *Id.* at 401.

203. 538 U.S. 329 (2003).

204. 471 U.S. 724 (1984).

205. 536 U.S. at 373.

206. *Ky. Ass'n. of Health Plans, Inc. v. Miller*, 538 U.S. 329, 339-40 (2002).

207. *Id.* at 342 (citations omitted).

208. *Id.* at 338-39.

Coming just a year after *Rush Prudential's* rejection of a section 502 challenge to state regulation of managed care practices, *Kentucky Health* continued to respect the role of state law in overseeing health care. However, any enthusiasm on the part of states, providers and patients was extinguished when the ground shifted yet again in *Aetna Health, Inc. v. Davila*.<sup>209</sup> What was not yet apparent in *Rush* was that Justice Thomas's pro-section 502 preemption dissent would prevail in 2004's *Aetna Health Inc. v. Davila*.<sup>210</sup> Moreover, by upending ERISA jurisprudence once again, the Court would imperil state law and thus leave patients and providers with few remedies for managed care practices that were likely to become even more hard-line if shielded from state law. And that is precisely what occurred in the aftermath of *Davila*.

#### Stage 6: Back to the Playbook: A Return to Broad Preemption Brings a Return to Managed Care Games

Since state regulation of managed care had survived ERISA preemption in *Travelers* through *Kentucky Health*, Texas appeared to be on firm ground in 1994 when it enacted its Health Care Liability Act to allow MCOs to be sued for negligent medical necessity determinations.<sup>211</sup> The law did not mandate coverage of any particular benefits, but simply directed MCOs to exercise ordinary care in "making health care treatment decisions," and imposed liability for harm proximately resulting from the breach of ordinary care.<sup>212</sup> *Aetna Health, Inc. v. Davila* consolidated two cases in which ERISA plan beneficiaries claimed their HMOs violated the statute by failing to exercise due care, one by denying coverage for a certain medication, and the other by denying an

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209. 542 U.S. 200 (2004). In hindsight, though, signs of a shift away from protecting patients appeared before both *Rush Prudential* (2002) and *Kentucky Health* (2003) and just a year after *Pegram* in *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), a non-health benefits case, involving a section 514 preemption challenge to a Washington statute requiring the automatic revocation upon divorce of a spouse's designation as a beneficiary of a non-probate asset. WASH. REV. CODE § 11.07.010(2)(A) (1994). The decedent died two months after divorcing his second wife, having never changed his designation of her as the beneficiary of the employment pension plan, and his children sued to recover the pension proceeds. The ex-wife argued that the statute was section 514 preempted and the Court agreed, finding an "impermissible connection [between state law and] ERISA plans" because the statute "binds plan administrators to a particular choice of rules for determining beneficiary status." 532 U.S. at 147. An additional "prohibited connection" resulted since the state rule affected claims processing and payment and thus disrupted Congress's goal of ensuring nationally uniform plan administration. *Id.* at 148. Although the state law fell within an area traditionally left to state regulation, the presumption against preemption yielded to clear indicia of Congress's intolerance for binding plan choices. *Id.* at 151-152.

210. *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

211. Texas Health Care Liability Act, TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (West 2004 Supp. Pamphlet) [hereinafter *THCLA*].

212. *Davila*, 542 U.S. at 212 (citing *THLCA* § 88.002).



extension of inpatient benefits.<sup>213</sup> Each patient initially complied with the MCO's decision and claimed to have sustained physical harm as a result.<sup>214</sup> Relying on the "indistinguishable"<sup>215</sup> precedent of *Pegram*, the Fifth Circuit viewed both suits as challenging non-fiduciary, mixed eligibility and treatment decisions under traditional and, as such, non-502 preempted state law.<sup>216</sup> As a result, it lacked removal jurisdiction and remanded to the state court. It did note, however, that the medical aspects of the MCOs' actions signaled that a section 514 defense was unlikely to succeed. This was the same court that had found just the opposite in *Corcoran*, but here, it explained that its earlier ruling had since been "undermine[d]" by the *Travelers* trilogy's "curtail[ment]" of the scope of section 514 preemption<sup>217</sup> as well as *Pegram*'s dicta suggesting no section 502 preemption of medical malpractice claims against an MCO.<sup>218</sup>

A unanimous Supreme Court saw things quite differently. Having authored *Rush*'s 4-justice dissent, Justice Thomas now spoke for all 9 in invoking ERISA's "extraordinary preemptive power,"<sup>219</sup> "expansive preemption provisions"<sup>220</sup> and "substantive regulatory requirements"<sup>221</sup> which showed that Congress had carefully balanced various remedies in forbidding compensatory damages under both section 502 and, through preemption, state law, too.<sup>222</sup> As a result, section 502 completely preempts state law challenges to medical necessity decisions because they qualify as claims for benefits. Even state laws that are saved from section 514 "relate to" preemption and do not replicate section 502 causes of action are section 502 preempted because they interfere with plan administration.<sup>223</sup> The Court's holding was a stunning change in direction, not only because it effectively left injured patients with no meaningful relief, but also because the Court unanimously overlooked or at least underplayed its recent ERISA rulings.

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213. *Id.* at 204.

214. *Id.* at 204-05. Specifically, Mr. Davila had an adverse drug reaction, resulting in hospitalization while Mrs. Calad experienced post-surgical complications that necessitated re-hospitalization.

215. *Roark v. Humana, Inc.*, 307 F.3d 298, 308 (5th Cir. 2002).

216. *Id.* at 315.

217. *Id.* at 314.

218. *Id.* at 315.

219. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) (citing *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66 (1987)).

220. *Id.* at 208.

221. *Id.*

222. *Id.* at 209.

223. To do so "would 'elevate form over substance and allow parties to evade' the pre-emptive scope of ERISA simply by relabeling their contract claims as claims for tortious breach of contract." *Id.* at 214 (quoting *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 211 (1985)).

Gone was *Pegram*'s implicit endorsement of at least some state remedies where (as in *Davila*) the plan had delivered covered health care benefits, but the health care itself had fallen short of what was medically necessary.<sup>224</sup> Moreover, notwithstanding Justice Thomas's reliance on ERISA's "substantive" requirements, the law in general and section 502 in particular say nothing about such circumstances. If anything, the absence of such provisions shows that in 1974, when managed care was in its infancy, Congress never intended to displace longstanding state tort remedies, especially in the traditionally state-controlled health care quality context. Any doubt about congressional intent should yield to *Travelers*' presumption *against* preemption given no clear indication that Congress silently deprived patients of meaningful remedies simply because they receive health benefits through an ERISA plan.<sup>225</sup>

As a result, traditional rules of statutory construction as well as the Court's own precedent argued *against* preemption of state law, especially where section 502 equitable relief does nothing for a patient who has already sustained injury following an MCO's failure to exercise due care in making medical necessity determinations. Yet, the *Davila* Court unanimously decided otherwise because here, the MCOs' decisions were actionable under section 502 unlike the non-section 502 mixed eligibility-treatment determinations in *Pegram*.<sup>226</sup> *Pegram* had focused on the content of the MCO's decision, emphasizing that a medical necessity determination blends medical and administrative choices, which are not readily uncoupled.<sup>227</sup> According to *Davila*, though, what really mattered in *Pegram* was not the nature of the HMO's decision, but the nature of the HMO making the decision.<sup>228</sup>

*Pegram* involved an HMO that was owned and operated by the same physician who provided care; accordingly, she could dictate the timing and location of an ultrasound without breaching the plan's fiduciary duties because she simultaneously acted as plan administrator and health care provider. In contrast, the *Davila* UR nurse's determination of the timing and location of post-surgical care was a purely administrative, non-medical, eligibility decision because the nurse was not a direct provider even though she

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224. See *supra* note 185 and accompanying text.

225. Senators Kennedy, McCain and others made exactly this point in their amicus brief for Respondent. 2002 U.S. Briefs 1845 at \*5; 2004 U.S. S. Ct. Briefs LEXIS 68 at \*\*10 ("In enacting ERISA, Congress believed it was providing a series of federal pension rights to workers and their families. Its focus was entirely on establishing new minimum protections, not eliminating a wide swath of long-standing traditional state protections.").

226. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 218 (2004).

227. *Id.*

228. *Id.*

effectively supplanted the treating physician's treatment protocol with her own.<sup>229</sup> That such a "benefits determination is infused with medical judgments does not alter this result."<sup>230</sup> Under ERISA, an aggrieved patient may seek equitable relief by filing a section 502 claim for breach of fiduciary duties.<sup>231</sup> With *Davila*, then, the decision-maker – rather than the decision itself – dictates available remedies, with no guarantee that any of those remedies will provide meaningful relief.

Consequently, in the unanimous view of our nation's highest court, a patient in severe pain, incapacitated by an acute health crisis, and most likely unaccompanied by legal counsel, should simply have paid for the extended stay or initiated complex – and expensive – litigation from her hospital bed. That hospitals often condition admission on proof of insurance coverage seemed irrelevant to the Court. In addition, even if the patient could pay the hospital costs up front, she would face the additional cost of retaining legal counsel to sue the plan since section 502's solely equitable relief precludes a contingent fee. Seeking a preliminary injunction to compel payment for the treatment would be equally impractical. Few healthy individuals, let alone those debilitated by illness, could shoulder the legal and financial challenges of mounting a Rule 65 challenge. And as a practical matter, post-harm equitable relief is typically worthless. Recognizing just how real and insurmountable these challenges are led one federal appellate judge to sum it up as follows: "[t]o the extent that participants are unable to seek an injunction compelling coverage, ERISA's remedial scheme is almost entirely illusory."<sup>232</sup> So much for ERISA's protection of plan participants and preservation of traditional state oversight of healthcare.

The years since *Davila*'s return to broad section 502 preemption show a return to aggressive managed care tactics, especially when it comes to preemption challenges of provider reimbursement claims. ERISA's shifting impact on provider payment suits reflects the Supreme Court's changing messages about ERISA's preemptive scope as well as varying opinions about the provider's status as an assignee of a patient's health benefits. Some courts have found that a provider can only collect if it has obtained a duly executed assignment of benefits from the patient, while others reason that such assignments have no effect since they are barred by the plan's contract with the beneficiary. Still others have held that because assignee claims derive from, and therefore "relate to" an ERISA benefits plan, the provider is limited to

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229. *Id.* at 218-19 (analogizing the fiduciary to a trustee of a medical trust).

230. *Id.*

231. *Id.* at 220-21.

232. *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 459 (3d Cir. 2003).

section 502's equitable remedies which may bar monetary relief, leaving the provider with no effective remedy.<sup>233</sup>

Before *Travelers*, broad section 514 preemption often—but, as usual, inconsistently—preempted an array of provider claims for reimbursement. In 1991, the Sixth Circuit in *Cromwell v. Equicor-Equitable HCA Corp.*<sup>234</sup> ruled that section 514 and section 502 preempted the hospital's state law claims<sup>235</sup> although the provider “could assert [a derivative section 502] claim as a ‘beneficiary’ of an employee benefit plan if it has received a valid assignment of benefits.”<sup>236</sup> Otherwise, as neither a plan participant nor fiduciary, the hospital had no independent standing to seek section 502 remedies and thus no way to collect for services rendered.<sup>237</sup> This prompted the dissent to observe:

[T]his procedure is emblematic of what seems to be an overzealous readiness in the federal courts to bar all state-law claims which even smell of ERISA under the broad umbrella of preemption without engaging in the complex case-by-case analysis which the statute and precedent require. As in this case, the result of such a boiler-plate unreflective approach to ERISA preemption is to frequently leave deserving claimants without recourse in state or federal court.<sup>238</sup>

In *Memorial Hospital v. Northbrook*, the hospital obtained the plan's verbal authorization before rendering care, but when the plan realized that the patient was not covered, it refused to pay.<sup>239</sup> The plan argued that it acted as a fiduciary administering ERISA benefits, a hospital cannot become an assignee of those benefits, and section 514 preempts any challenge to its payment decisions.<sup>240</sup> Working through the “preemption thicket,”<sup>241</sup> the court agreed with regard to the state claims for negligent misrepresentation, equitable estoppel, and breach of contract since these were brought as an assignee and thus derived from the patient's right to benefits, and the patient in this case was not covered.<sup>242</sup> However, section 514 did not preempt the state

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233. *Hobbs v. Blue Cross Blue Shield of Ala.* 276 F.3d 1236, 1241 (11th Cir. 2001).

234. 944 F.2d 1272 (6th Cir. 1991).

235. “Appellants filed suit in state court alleging breach of contract, promissory estoppel, negligence and breach of good faith based on their reasonable reliance on Equicor's oral assurances of coverage.” *Id.* at 1275.

236. *Id.* at 1278.

237. *Id.*; accord *Riverside Med. Assocs. v. Humana, Inc.*, No. 06-61490-CIV-COHN, 2006 U.S. Dist. LEXIS 93739 (S.D. Fla. Dec. 28, 2006).

238. *Cromwell*, 944 F.2d at 1279 (Jones, J., dissenting).

239. 904 F.2d 236 (5th Cir. 1990).

240. *Id.* at 247-48.

241. *Id.* at 248.

242. As an early preemption case, it is not surprising that the Fifth Circuit had no problem with the case's initial removal from state to the federal district court based on section 514 preemption. *Id.*

statutory claim for unfair insurance practices (specifically, negligent misrepresentation of coverage) since it was not, as the plan had argued, “a derivative claim for benefits.”<sup>243</sup> Moreover, the court stressed that although ERISA preemption may leave patients with no meaningful remedies,<sup>244</sup> leaving health care providers with none could not be tolerated because:

If providers have no recourse under either ERISA or state law in situations such as the one *sub judice* (where there is no coverage under the express terms of the plan, but a provider has relied on assurances that there is such coverage), providers will be understandably reluctant to accept the risk of non-payment, and may require up-front payment by beneficiaries—or impose other inconveniences—before treatment will be offered. This does not serve, but rather directly defeats, the purpose of Congress [to protect employees and their beneficiaries] in enacting ERISA.<sup>245</sup>

ERISA challenges to provider reimbursement claims seemed to wane after *Travelers* appeared to limit section 514 preemption’s usefulness in evading liability. But since *Davila*’s return to broad section 502 preemption, payers are increasingly resisting or delaying payment, and raising both complete and “relate to” challenges when sued for reimbursement. For example, in 2007’s *Mem’l Hermann Hosp. Sys. v. Aetna Health Inc.*, a hospital brought contract, tort and statutory claims against an HMO for failure to make prompt payment.<sup>246</sup> The case involved the same jurisdiction as *Northbrook* as well as the same state insurance statute, but unlike *Northbrook*, benefits were clearly covered and payment was due within forty-five days of billing.<sup>247</sup> The defendant relied on section 502 to remove the case; although this strategy failed, it did succeed in subjecting the hospital to additional delays and costs in recouping the \$1.2 million owed for treating the patient.<sup>248</sup>

In *Louisiana Health Service & Indemnity Co. v. Rapides Healthcare System*, a payer refused to honor assignments of plan benefits to

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at 243.

243. *Id.* at 247.

244. *Id.* at 248 (acknowledging that it had “held under different circumstances that ERISA preemption may occur even though ERISA itself could not offer an aggrieved employee a remedy for alleged misrepresentations. That principle should not be extended, however, to encompass third-party providers . . .”).

245. *Id.* at 247-248. The Fifth Circuit’s explicit concern for congressional intent to protect plan participants is impressive but remarkable since this was entirely absent from its decision in *Corcoran* to deny relief to the parents whose pregnancy ended when their plan substituted its own fetal monitoring regimen for that of the treating specialist. See *supra* note 66 and accompanying text.

246. CIVIL ACTION H-06-00828, 2007 U.S. Dist. LEXIS 42126 (S.D. Tex. June 11, 2007).

247. *Id.* at \*2-3.

248. *Id.* at \*\*43-45 (asserting section 502 complete preemption as the basis for federal removal jurisdiction).

two hospitals on the ground that section 502 and section 514 preempted the Louisiana state assignment statute.<sup>249</sup> The Fifth Circuit found no “relate to” preemption because, unlike the Texas HMO liability statute in *Davila*, the Louisiana law made no mention of ERISA plans, imposed no obligations on them, and created no alternative remedies.<sup>250</sup> The plan’s obligations would be the same regardless of who brought that claim since the assignment statute “merely passes the sole enforcement mechanism—ERISA section 502—from patient to hospital.”<sup>251</sup> Despite so much Supreme Court “guidance” by this point, the Fifth Circuit still struggled and acknowledged that its own decision directly conflicted with those of the Eighth and Tenth Circuits, which had found preemption of state assignment statutes.<sup>252</sup> Its strongest basis for rejecting a similar approach was that those cases were decided before the *Travelers* Court’s return to “a traditional analysis of preemption,” and, thus, had erroneously failed to employ the starting presumption in favor of upholding traditional state law.<sup>253</sup>

What the court did not mention, however, is that post-*Travelers* courts had also found section 514 to preempt state assignment statutes. The First Circuit did so with regard to Puerto Rico’s statute in *City of Hope National Medical Center v. Healthplus, Inc.*, reasoning that section 514 prevents a state from restricting the ability of the plan to enforce a non-assignment provision in a benefits contract since Congress intended it to be negotiated by the parties.<sup>254</sup> The problem with this is that neither the patient nor the provider had any say in the negotiations, which effectively deprived them of any meaningful remedies. Plus, as *Mem’l Hermann Hosp.* and *La. Health Serv.* show, even when a provider wins the preemption argument, it still faces additional delays and costs of having to sue for payment.<sup>255</sup> Thus, that providers routinely obtain assignments of ERISA health benefits does not mean that they will routinely obtain prompt payment. And, as long as some courts find for some MCOs in some cases, ERISA preemption defenses, along with the litigation costs of opposing it, will continue. What will also continue is that state law will not fulfill an essential function of allowing actors to predict the legal

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249. 461 F.3d 529, 531 (5th Cir. 2006); LA. REV. STAT. ANN. § 40:2010 (2008).

250. *Louisiana Health Serv.*, 461 F.3d at 534-35.

251. *Id.* at 536.

252. *Id.* at 540 (citing *St. Francis Reg’l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460 (10th Cir. 1995); *Ark. Blue Cross & Blue Shield v. St. Mary’s Hosp., Inc.*, 947 F.2d 1341 (8th Cir. 1991)).

253. *Id.* at 540.

254. 156 F.3d 223, 229 (1st Cir. 1998).

255. *Mem’l Hermann Hosp. Sys. v. Aetna Health Inc.*, CIVIL ACTION H-06-00828, 2007 U.S. Dist. LEXIS 42126, at \*3, \*18 (S.D. Tex. June 11, 2007).

consequences of their actions as well as the conduct of others.

### Stage 7: ERISA Calls a Foul on State “Play or Pay” Mandates

After several decades of increasingly nuanced and unpredictable ERISA rulings, patients, providers and states are justifiably frustrated. And, as the complexity of ERISA disputes has grown, so too have health care expenditures and the ranks of the uninsured. These developments are not entirely unrelated. Rather, given congressional intransigence, states are increasingly taking the lead in health care reform, especially with regard to expanding coverage. While any state reform effort will encounter political opposition, ERISA presents a much more difficult obstacle. Maryland learned this the hard way in the first case of what will surely be the next wave of ERISA preemption litigation: *Retail Industrial Leaders Ass’n v. Fielder*.<sup>256</sup>

Facing annual Medicaid costs of \$5 billion and budgetary shortfalls exceeding \$100 million, Maryland enacted its employer “Fair Share Act” in 2006.<sup>257</sup> Although facially neutral, the law basically targeted Wal-Mart, which employed 16,000 workers in Maryland, (many of whom had no or inadequate coverage) by requiring employers of 10,000 or more to devote at least eight percent of their total payrolls to employees’ health care or health insurance costs. An employer could satisfy this obligation through direct benefits payments or paying the difference between current spending and eight percent to the state’s Medicaid fund.<sup>258</sup>

Wal-Mart did not challenge the law, but the Retail Industry Leaders Association (RILA) did, characterizing this “fair share” measure as a section 514 preempted employer mandate. Maryland countered that it was a generally applicable revenue statute like the one that survived section 514 preemption in *Travelers*.<sup>259</sup> The court agreed with RILA, finding that the law effectively mandated a minimum level of health benefits while impermissibly interfering with plan administration through its reporting requirements. The threat of inconsistent administrative burdens in violation of ERISA had already been realized by similarly intended, but differing financial and reporting requirements in Minnesota and New York’s Suffolk County. Despite no express reference to ERISA plans, Maryland’s Fair Share law inevitably created a connection with the plan that

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256. 475 F.3d 180 (4th Cir. 2006).

257. *Id.* at 199; Fair Share Health Care Fund Act, 2006 MD. CODE ANN., LAB. & EMPL. §§ 8.5-101 to -107 (2009).

258. *Fielder*, 475 F.3d at 183.

259. See *supra* note 75 and accompanying text.

triggered “relate to” preemption.<sup>260</sup>

RILA also succeeded in dismantling Suffolk County’s fair share ordinance in *Retail Industrial Leaders Ass’n v. Suffolk County*.<sup>261</sup> With reporting obligations that mirrored Maryland’s, the “Suffolk County Fair Share for Health Care Act”<sup>262</sup> directed large, non-unionized retailers to meet an annual “public health care cost rate” in health care spending for each full or part-time employee.<sup>263</sup> As in *Felder*, the ordinance’s payment alternatives did not obviate the need to restructure plans in violation of section 514.<sup>264</sup>

Massachusetts’ 2006 “Act to Control Costs and Improve Quality” took a much broader approach to health care reform, using a blend of insurance market reforms,<sup>265</sup> individual mandates<sup>266</sup> and employer “incentives” to achieve universal coverage by 2009.<sup>267</sup> Critical to the Massachusetts’ plan’s success are the law’s “play or pay” or “fair share” requirements that employers with more than 10 full-time workers make a “reasonable contribution” to their employee health care. This can be accomplished by covering at least twenty-five percent of the workforce, paying at least a third of the cost of all workers’ individual plans, or making the annual “fair share” contribution, which, in 2008, was \$295 per full-time worker.<sup>268</sup> In addition, employers of ten or more full and/or part time employees must offer Internal Revenue Code section 125 “cafeteria plans” to enable workers to use pre-tax dollars in paying for coverage.<sup>269</sup> Failure to offer section 125 plans triggers significant “free rider” penalties to fund uncompensated care sought by that employer’s workers on five or more occasions.<sup>270</sup>

260. See *supra* note 75 and accompanying text.

261. 497 F. Supp. 2d 403 (E.D.N.Y. 2007).

262. SUFFOLK COUNTY, N.Y., REG. LOCAL LAW §§ 325-1-7 (2005).

263. *Retail Indus. Leaders v. Suffolk County*, 497 F. Supp. 2d at 406 \*\*3-5, 15.

264. *Id.* at 418.

265. Among these is the newly created “Commonwealth Connector,” which assists individuals and small businesses of fewer than 50 employees to find suitable private plans and promote consumer driven competition.

266. To date, the greatest criticism of the individual mandate is that it may not be economically sustainable since it is feared that premiums will be too high for the insured, too low for the insurer and therefore require too much in the way of state subsidies.

267. Act § 15 (adding M.G.L.MASS. GEN. LAWS ANN. ch. 118E § 9A (West 2008)); see also Tim Murphy, *The Massachusetts Health Plan: How Did They Do It?*, 5-6 (Remarks at Alliance for Health Reform Conference, May 8, 2006) at [http://www.allhealth.org/briefingmaterials/050806\\_Transcript\\_mass-164.pdf](http://www.allhealth.org/briefingmaterials/050806_Transcript_mass-164.pdf) (last visited Feb. 16, 2010).

268. MASS. GEN. LAWS ANN. ch. 149, § 188. (West 2008).

269. MASS. GEN. LAWS ANN. ch. 151F (West 2008); THE COMMONWEALTH OF MASSACHUSETTS, THE COMMONWEALTH CONNECTOR: EMPLOYER HANDBOOK 8, <https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/Employer/Overview/Employer%2520Handbook.pdf> 2009.

270. The actual penalties will range from ten percent to one hundred percent of the cost of the



Early supporters of the fair share “incentives” included two of the state’s largest health insurers—Blue Cross Blue Shield and Harvard Pilgrim Health Care—which would benefit from higher enrollments and employer contributions.<sup>271</sup> Yet, some criticize the incentives for effectively reducing and/or taxing individual wages,<sup>272</sup> and unduly incentivizing small to medium sized businesses to leave the state.<sup>273</sup> A competing concern is that an annual fair share contribution of just a few hundred dollars per worker is so low that it will entice employers currently offering health benefits to drop coverage.<sup>274</sup>

Within Massachusetts itself, the law’s chief promoters and detractors have paid scant attention to the shadow of ERISA preemption. Clearly, the design of the law reflects a conscious attempt to circumvent preemption. The focus on fostering consumer driven competition in insurance markets and the reliance upon individual mandates make the statute at least appear to be more ERISA friendly than the Maryland and Suffolk County efforts to target “big box” retailers. If anything, the statute might be even more vulnerable than its Maryland counterpart to a section 514 “relate to” challenge. First, by applying to all employers with ten or more workers and imposing more requirements, it risks antagonizing far more employers than just Wal-Mart. Second, although the IRS does not categorize section 125 plans as ERISA plans, their compulsory inclusion in a benefits package might be problematic under section 514 given their attendant costs and administrative adjustments for affected employers.<sup>275</sup>

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services. Robert Moffit & Nina Owcharenko, *Understanding Key Parts of the Massachusetts Health Plan* (Heritage Found., Web Memo No. 1045, 2006) at <http://www.heritage.org/Research/HealthCare/wm1045.cfm> (last visited Feb. 16, 2010). Because § 125 plans permit pre-tax, employee contributions, they may offer savings of up to forty percent of each dollar contributed. They also enable the employer to save approximately \$160 in annual federal withholding tax for each participating employee, although it costs about \$100 per year per employee to create and administer a health-only cafeteria plan and several national companies compete for this business. RICHARD CAUCHI, NAT’L CONFERENCE OF STATE LEGISLATURES, STATES’ USE OF “CAFETERIA PLANS” TO PROVIDE HEALTH INSURANCE (2009) at <http://www.ncsl.org/default.aspx?tabid=14515> (last visited Feb. 16, 2010).

271. Jeffrey Krasner, *Business Leaders Suggest Health Law Too Easy on Firms*, BOSTON GLOBE, Feb. 2, 2007, at C1.

272. Nina Owcharenko & Robert Moffit, *The Massachusetts Health Plan: Lessons for the States* (Heritage Found., Background No. 1953, 2006), <http://www.heritage.org/Research/HealthCare/bg1953.cfm>.

273. *Id.*

274. Krasner, *supra* note 270. To forestall such a result, one bill has already been submitted that would compel companies to pay for at least 50% of individual premiums. S. 661, 185th Mass. Gen. Court, (Mass. 2007).

275. See PATRICIA A. BUTLER, CALIFORNIA HEALTHCARE FOUND., EMPLOYER CAFETERIA PLANS 2 (2008), <http://www.chcf.org/documents/insurance/EmployerCafeteriaPlans.pdf>. (“[B]ecause the definition of employer group health coverage is different under ERISA than under the federal tax code, as long as employers do not endorse or promote specific individually purchased health insurance policies, [§ 125 plans] should not be subject to ERISA. Nor should a state requirement

Third, the annual fair share contribution might be viewed as an employer mandate and/or interference with plan administration amounting to a section 514 preempted "connection" with a plan. In this regard, the statute's establishment of the Commonwealth "Connector" seems a most unfortunate choice of terminology. The state would argue that this measure simply creates options, not a mandate, and that any payments make the law a funding measure with the kind of indirect economic impact that evaded section 514 preemption in *Travelers*. Given that this argument failed in both *Fielder* and *Retail Industrial Leaders v. Suffolk County*, it is not clear whether the law would survive. So far, however, there has been no ERISA challenge, although this is likely due to the extraordinary efforts to build political consensus during the law's design and enactment instead of the lack of any vulnerability in the statute itself. A similar approach was taken by Vermont's 2006 reform initiative, which requires employers with uninsured workers to make a quarterly "Health Care Premium Contribution" of \$1 per day for each full time equivalent employee.<sup>276</sup> Like that of Massachusetts, Vermont's mandatory employer contribution has not provoked an ERISA preemption challenge despite its inherent vulnerability.

That state "fair share" or "play or pay" measures will inspire the same judicial inconsistency as past stages of ERISA preemption litigation became clear in *Golden Gate Restaurant Association v. City of San Francisco*.<sup>277</sup> Unlike *Fielder's* and *Retail Industrial Leaders v. Suffolk County's* findings of section 514 "relate to" preemption, the Ninth Circuit upheld the employer spending requirements of San Francisco's "Health Care Security Ordinance."<sup>278</sup> The ordinance applies to for profit employers doing business in the city and averaging twenty "covered" employees per quarter and to nonprofit employers that average fifty.<sup>279</sup> Each quarter, these employers must make "required health care expenditures"<sup>280</sup> determined by multiplying the total

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that employers offer Section 125 plans be preempted by ERISA."). However, the National Conference of State Legislatures points out that "states still cannot regulate 'self-insured' health plans sponsored by many large employers. Drafters need to recognize that care is needed to avoid a challenge to any broader law." CAUCHI, *supra* note 304.

276. Under Vermont's 2006 Health Care Affordability Act, which took effect on April 1, 2007, a quarterly assessment is due if the employer does not cover all employees or has uninsured employees. The law permitted an exemption for up to a specified number of full time equivalent employees. Up to eight full time equivalent employees may be exempted for fiscal years 2007 and 2008, six in 2009, and four in 2010. VT. STAT. ANN. tit. 21, §§ 2002(5), 2003(a) (2007).

277. 546 F.3d 639 (9th Cir. 2008), *petition for cert. filed*, 77 U.S.L.W. 3691 (U.S. Jun. 5, 2009) (No. 08-1515).

278. *Id.* at 642 (citing S.F. CAL. ADMIN. CODE § 14.3(a) (2007)).

279. As defined by § 14.1(b)(2), "covered employees" (1) work in the City, (2) work at least ten hours per week, (3) have worked for the employer for at least ninety days, and (4) are not otherwise excluded from coverage under the Ordinance.

280. *Id.* at §§ 14.1(b)(3), (11), (12).

number of hours paid for each covered worker by “the applicable health care expenditure rate.”<sup>281</sup> Employers must keep, and provide the City with reasonable access to “accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year.”<sup>282</sup> Failure to abide by the recordkeeping provisions raises a presumption of nonpayment, which can only be rebutted by clear and convincing evidence.<sup>283</sup> Under certain circumstances, self-funded plans must meet the spending requirement, although there is no need to “keep track of their actual expenditures for each employee.”<sup>284</sup>

Given its requirement of quarterly payments based on each worker’s hours, shifting health care expenditure rates, and quarterly records of those payments, San Francisco’s initiative seems even more administratively intrusive than the preempted fair share measures of *Felder* and *Retail Industrial Leaders v. Suffolk County*. Plus, the potential for multiple and potentially inconsistent obligations clearly exists since Maryland, Suffolk County and Massachusetts have all used different “play or pay” rules. Consequently, the federal district court found section 514 preemption,<sup>285</sup> but the Ninth Circuit reversed because the payment options provided “a legitimate alternative to establishing or altering ERISA plans” since the employer or at least the employee stood to gain from whatever way the employer chose to meet its fair share obligation.<sup>286</sup> As a result, the ordinance only exerted the kind of indirect economic impact that survived section 514 preemption in *Travelers*.<sup>287</sup>

Interestingly, the Ninth Circuit found no conflict with the Fourth Circuit’s *Felder* ruling because of the Maryland law’s lack of any *quid pro quo* for fair share payments to the state effectively

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281. S.F. ADMIN. CODE §§ 14.3(a), 14.1(b)(8). At the time of the Ninth Circuit’s ruling, the per employee health care expenditure was \$1.17 per hour for for-profit employers with twenty to ninety-nine employees and non-profit employers with fifty or more employees, and \$1.76 per hour for for-profit employers with 100 or more workers. *Golden Gate*, 546 F.3d at 644, (citing San Francisco Office of Labor Standards Enforcement Reg. 5.2(A) (2007)). Reg. 5.2(A) (2007) [hereinafter *ESR*] (implementing the employer spending requirements of the San Francisco Health Care Security ordinance).

282. *Golden Gate*, 546 F.3d at *Id.* at 645 (“but it does not require them ‘to maintain such records in any particular form.’”) (citing S.F. ADMIN. CODE § 14.3(b)(I)).

283. *Id.* at 645 (citing S.F. ADMIN. CODE § 14.3(b)(ii)).

284. “An employer providing ‘health coverage to some or all of its covered employees through a self-funded/self-insured plan ‘will’ comply with the spending requirement . . . if the preceding year’s average expenditure rate per employee meets or exceeds the applicable expenditure rate’ for the employer.” *Id.* (citing *ESR* Reg. 6.2(B)(2)).

285. *Golden Gate Rest. Ass’n v. City & County of San Francisco*, 535 F. Supp. 2d 968, 979–80 (N.D. Cal. 2007) (entering summary judgment for Restaurant Association and enjoining implementation of Ordinance’s ordinance’s employer spending requirements).

286. *Golden Gate*, 546 F.3d at 660.

287. *Id.*

left employers with only one “rational choice,” i.e., “to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.”<sup>288</sup> Unmentioned was that an employer and even an employee might want to forego any “quos” in order to avoid the ordinance’s administrative and economic costs. For this reason, it is not at all clear that other courts would find *Golden Gate* and *Fielder* so easy to reconcile.

*Fielder* and *Golden Gate* demonstrate how cash-strapped states cannot count on the courts to free them of the binds of ERISA preemption as they tackle health care reform. By July 2009, however, financial need had already trumped any reservations about legal ambiguity in the three states that enacted universal coverage initiatives, and an additional fourteen that have attempted or are at least considering similar measures.<sup>289</sup> As occurred in Maryland, Massachusetts, San Francisco and Suffolk County New York, fair share contributions<sup>290</sup> and required section 125 cafeteria plans are common strategies for expanding coverage while promoting affordability.<sup>291</sup>

Nevertheless, as *Fielder*, *Retail Industrial Leaders v. Suffolk County* and *Golden Gate* reveal, the long-term viability of play of pay provisions are far from certain if courts are left to interpret sections 502 and 514 with no input from Congress. Although plaintiffs have petitioned for certiorari in *Golden Gate*, there is no need to await the outcome to know that the instability of the Supreme Court’s preemption jurisprudence will persist. Although not an ERISA case, its 2009 ruling in *Wyeth v. Levine* made it abundantly clear that inconsistency and unpredictability are all that can be expected when it comes to preemption.<sup>292</sup> Most striking is the concurrence of Justice Thomas, whose insistence on restrictive preemption is nothing short of bewildering given that his *Pegram* dissent fueled the Court’s return to broad section 502 preemption in *Davila*.<sup>293</sup>

*Wyeth* concerned a successful state law product liability claim against a pharmaceutical manufacturer for its failure to provide

288. *Id.* (quoting *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 193 (4th Cir. 2007)).

289. As summarized in a report by the Kaiser Family Foundation, universal coverage measures have been enacted in Maine, Massachusetts and Vermont and have been considered in California, Colorado, Connecticut, Illinois, Iowa, Kansas, Minnesota, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Washington, and Wisconsin. HENRY J. KAISER FAMILY FOUNDATION, STATES MOVING TOWARD COMPREHENSIVE HEALTH CARE REFORM (2009), <http://www.kff.org/uninsured/upload/State-Health-Reform1.pdf>.

290. See *supra* notes 257–268 and accompanying text.

291. Section 125 plans are now required in Kansas, Massachusetts, Minnesota, New Jersey, and Rhode Island, optional and under consideration in Colorado and New York. See *supra* note 264; RICHARD CAUCHI, *States’ Use of “Cafeteria Plans” to Provide Health Insurance*, NCSL (May 2009) available at <http://www.ncsl.org/default.aspx?tabid=14515> (last visited Oct. 26, 2009).

292. *Wyeth v. Levine*, 129 S. Ct. 1187 (2009).

293. *Id.* (Thomas, J., concurring); see *infra* notes 237–41 and accompanying text.

adequate labeling regarding the risks of “IV push” administration of the drug Phenergan.<sup>294</sup> Since the FDA had approved the original label and subsequent revisions, Wyeth argued that the Food, Drug and Cosmetics Act preempted state common law claims.<sup>295</sup> The state courts disagreed<sup>296</sup> and, ultimately, the U.S. Supreme Court did, too. Employing the kind of traditional preemption analysis used in *Travelers*,<sup>297</sup> the *Wyeth* majority<sup>298</sup> characterized congressional purpose as “the ultimate touchstone in every pre-emption case”<sup>299</sup> and emphasized that

[I]n all pre-emption cases, and particularly in those in which Congress has ‘legislated . . . in a field which the States have traditionally occupied,’ . . . we ‘start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.’<sup>300</sup>

That drug labeling had been subject to federal oversight for over a century did not alter this result since “Congress does not cavalierly pre-empt state law causes of action.”<sup>301</sup>

Although the federal statute at issue contained a preemption clause, it did not expressly preempt state tort claims. This lack of preemption, coupled with Congress’s “certain awareness of the prevalence of state tort litigation” was “powerful evidence” that it never intended to preclude patients from asserting tort claims to challenge the safety of a drug or the adequacy of its labeling.<sup>302</sup> Consequently, neither the FDCA nor FDA regulations preempted the patient’s common law claims.<sup>303</sup>

Ironically, ERISA, like the FDCA, has an express preemption clause in section 514 that says nothing about state tort claims. Plus, both drug safety and health care are encompassed by traditional

294. *Id.*

295. 21 U.S.C. §§ 301 (et. seq.) [hereinafter “FDCA”].

296. *Levine v. Wyeth*, 944 A.2d 179, 186–194 (Vt. 2006).

297. *See supra* note 74 and accompanying text.

298. Justice Stevens’ opinion was joined by Justices Souter, Ginsberg, Breyer and Kennedy. Justice Thomas concurred, but only in the result. 129 S.Ct. at 1190.

299. *Id.* at 1194 (citing *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485, (1996) (internal quotation marks omitted from original) and *Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963)).

300. *Id.* at 1194–95 (quoting *Medtronic*, 518 U.S. at 485 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947))).

301. *Id.* at 1195, n. 3 (quoting *Medtronic*, 518 U.S. at 485).

302. *Wyeth*, 129 S.Ct. at 1200. To underscore this point, the majority quoted the unanimous decision of *Bonito Boats, Inc. v. Thunder Craft Boats, Inc.*, 489 U.S. 141, 166–67 (1989), which explained that “[t]he case for federal pre-emption is particularly weak where Congress has indicated its awareness of the operation of state law in a field of federal interest, and has nonetheless decided to stand by both concepts and to tolerate whatever tension there [is] between them.” (internal quotation marks omitted).

303. *Wyeth*, 129 S.Ct. at 1204.

state authority, with tort remedies enjoying longstanding prominence in protecting individuals. Notwithstanding these glaring parallels, the *Wyeth* majority's use of a 1992 *Travelers*-like rationale, after moving so far away from it in *Davila* in 2004 is not just ironic; it is baffling.

Nowhere is the Court's blithe inconsistency more astonishing than in Justice Thomas's concurrence. After all, when he dissented in *Pegram* and wrote for a unanimous court in *Davila*, he favored preemption due to ERISA's extraordinary preemptive power,<sup>304</sup> "expansive preemption provisions"<sup>305</sup> and "substantive regulatory requirements."<sup>306</sup> That these operate in an area of traditional state law without expressly preempting common law claims or permitting comparable relief did nothing to dissuade him from finding that Congress implicitly intended to preempt state tort claims arising out of medical necessity decisions.<sup>307</sup> In *Wyeth*, though, he refused to join with the majority not because they had erred by finding no preemption, but because they had not gone far enough in deferring to state law!

Justice Thomas explained that he had become "increasingly skeptical" of "far-reaching implied pre-emption doctrines" that focus on congressional purpose and unconstitutionally "wander from the statutory text."<sup>308</sup> Even though he had similarly wandered in both *Pegram* and *Davila*, he did not hesitate in chastising *Wyeth*'s majority as well as the dissent for straying from the statute's explicit text especially because text embodies legislative compromise.<sup>309</sup> In his view, "our federal system in general, and the Supremacy Clause in particular, accords preemptive effect to only those policies that are actually authorized by and effectuated through the statutory text."<sup>310</sup> Thomas argued that the FDCA's failure expressly to preempt state tort law was therefore dispositive; and that the majority should not have started with a presumption against preemption and then looked to the text and its overall purpose for evidence of a preemptive intent.<sup>311</sup>

Dissenting, Justice Alito, joined by Chief Justice Roberts and

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304. *Davila*, 542 U.S. at 207 (citing *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, at 65–66 (1987)).

305. *Id.* at 208.

306. *Id.*

307. See *supra* notes 187–226 and accompanying text.

308. *Wyeth*, 129 S.Ct. at 1205 (Thomas, J., concurring).

309. *Id.* at 1216.

310. *Id.*

311. *Id.* "Certainly, the absence of a statutory provision pre-empting all state tort suits related to approved federal drug labels is pertinent to a finding that such lawsuits are not pre-empted. But the relevance is in the fact that no statute explicitly pre-empt the lawsuits, and not in any inferences that the Court may draw from congressional silence about the motivations or policies underlying Congress' failure to act. (Thomas, J.)"

Justice Scalia, agreed that a starting presumption against preemption was unnecessary where conflict preemption is alleged.<sup>312</sup> However, Congress's objectives still mattered because "the ordinary principles of conflict pre-emption turn solely on whether a State has upset the regulatory balance struck by the federal agency."<sup>313</sup> Upon examining the FDCA's purpose, five justices found that Congress never intended to preempt state tort claims and three concluded that preemption was needed to fulfill Congress's choice of the FDA as the sole arbiter of drug safety.<sup>314</sup>

Although *Wyeth* is not an ERISA case, it could and – if the Court is at all consistent (which obviously, it has not been) – *should* complicate ERISA preemption. Should the Supreme Court review *Golden Gate*, it will surely discuss the Fourth and Ninth Circuit's competing views of ERISA preemption of state fair share requirements. *Davila's* broad view of preemption suggests that the Fourth Circuit's position will prevail and the Court will find the San Francisco ordinance to be preempted and probably do so on both section 514 and section 502 grounds. But *Wyeth* could throw a wrench into the Court's approach. According to Justices Thomas, Roberts, Scalia and Alito in *Wyeth*, *Travelers'* strong presumption against preemption should be used sparingly if at all, which would increase the likelihood of preemption. Yet the remaining five justices along with Justice Thomas would view the lack of ERISA's express preemption of state law, coupled with Congress's awareness of the operation of state tort law in a traditional area of state concern as militating against preemption. This could make preemption less likely. As it has for over thirty years, then, the Supreme Court's ERISA preemption precedents predict nothing more than a coin flip. Consequently, instead of relying on *stare decisis*, or standing firm over time,<sup>315</sup> litigants – particularly states – should prepare for *dejicere decisis*<sup>316</sup> as the Supreme Court continues to shake, rattle and roll through these cases.

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312. *Id.* at 1229, n. 14 (Alito, J., dissenting).

313. *Id.* at 1220.

314. In his dissent, which was joined by Chief Justice Roberts and Justice Scalia, Justice Alito observed "[t]hus, it is not true that 'this Court has long' applied a presumption against pre-emption in conflict pre-emption cases." *Id.* at 1229, n. 14 (quoting the majority's earlier statement at 1195, n. 3).

315. "Stare" has been defined as to "stand, stand still, stand firm; remain, rest. . . ." See *Whitakers Words*, <http://www.archives.nd.edu/cgi-bin/wordz.pl?keyword=stare> (last visited Oct. 21, 2009).

316. "Dejicere" has been defined as to "throw/pour/jump/send/put/push/force/knock/bring down; cause to fall/drop; hang" – an apt description of how the Supreme Court has done anything but stand firm in its handling of ERISA preemption cases. See *Whitaker's Words*, <http://www.archives.nd.edu/cgi-bin/wordz.pl?english=jump>: (last visited Oct 21, 2009).

*c. Overtime: If That Was Then and This is Now, What Comes Next?*

Whether Congress fulfills President Obama's demand for "health insurance reform," achieves his earlier goal of broader "health care" reform, or does nothing at all, it must finally clarify: 1) the appropriate scope of ERISA preemption, and 2) the availability of ERISA and state remedies. Without such clarification, ERISA preemption will still bedevil patients seeking compensation for medically necessary care that comes too late or not at all.<sup>317</sup> It will continue to ensnare providers seeking pre-authorization and ultimate payment as well as obstruct interstitial state action, particularly when it comes to the kind of state and local innovations to expand access that occurred in Maryland, Massachusetts, and elsewhere. That Congress needs to release state law from the confusion of ERISA's text and judicial interpretation thereof is nothing new; to date, however, the federal response has been sporadic and disappointing.

When the House of Representatives returned to Democratic control in January 2007, "The Health Partnership Through Creative Federalism Act" was introduced to encourage health reform at the state level.<sup>318</sup> During hearings in May of 2007, representatives of the National Business Coalition on Health, the American Benefits Council, and "The ERISA Industry Committee", among others, testified to the adverse effects of liberalizing ERISA waivers. An attorney who represents large employers and the ERISA Industry Committee,<sup>319</sup> identified four reasons for preserving the status quo: (1) Preemption is needed to permit innovations that will continue and build upon the success of employer based health care; (2) "Congress carefully considered the effect of ERISA preemption on state health reform efforts more than 30 years ago, when ERISA was enacted" and "concluded that preemption was necessary to eliminate the threat of conflicting state and local regulation of employee benefit plans";<sup>320</sup> (3) Unlike, for example, Medicaid waivers, granting ERISA waivers would be

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317. Section 132 of H.R. 3200 requires internal and binding external review, including expedited reviews of urgent claims. Hopefully, this will reduce the number of *Corcoran*- and *Danca*-like tragedies, but it will certainly not eradicate them since, as demonstrated in the state medical malpractice context, juries regularly award relief despite a finding of no liability by pre-trial screening panels. H.R. 3200, 11th Cong. (2009). The House bill does not address this problem other than § 151's statement that § 514 of ERISA remains in effect. H.R. 3200, 111th Cong. § 151 (2009); 29 U.S.C. § 1144 (2006).

318. GovTrack.us., H.R.506 [110<sup>th</sup>], available at <http://www.govtrack.us/congress/bill.xpd?bill=h110-506> (last visited Oct. 26, 2007) (providing for innovation in health care through State initiatives that expand coverage and access).

319. *Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives Before the Subcomm. On Health, Employment, Labor and Pensions of the H. Comm. On Education and Labor*, 110th Cong. 39-40 (2007) (statement of Amy N. Moore, Covington & Burling LLP).

320. *Id.* at 3.



too complicated since no waiver approval process currently exists; and (4) “[S]tates do not need ERISA waivers” to accomplish needed reforms since problems such as “insuring the unemployed, providing reliable and accessible information on health care cost and quality, making affordable insurance available to individuals and small groups – are outside the scope of ERISA’s preemption provisions.”<sup>321</sup>

That an advocate for large employer interests sought to preserve preemption came as no surprise. What is so troubling, however, is that the grounds asserted were not just self-interested, but also inaccurate or at least naïve. First, many employers have made admirable efforts to bring better coverage to greater numbers at lower costs, but this should not entitle them to free—and sole—rein in deciding how patients and providers are treated or how the uninsured and state payers are affected. Second, as demonstrated by 35 years of section 502 and section 514 litigation, Congress did not consider preemption’s impact on “state health care reform” when it passed ERISA. It focused instead on pension plan reform and paid little attention to the full ramifications of preemption for a managed care industry that was in its infancy during the 1970’s. That the federal HMO Act contemporaneously required employers to offer HMO plans is just one of many indicia that health plan accountability was simply not on the congressional radar. Third, arguing that waivers are too complicated because there is no system in place is akin to arguing in the 1930’s that income taxes could never be levied since there was no system in place. The idea simply makes no sense, especially with the Medicaid waiver program as a ready analogue to put an ERISA waiver process in place. Fourth, the problems of improving quality and expanding coverage which are described as “outside the scope” of ERISA preemption<sup>322</sup> have ironically been placed within that scope by large employers seeking to evade state oversight and defeat state health care reform initiatives. As demonstrated by patients, providers and states during three decades of legislative and judicial wrangling, ERISA preemption has presented huge obstacles to everyone but employers. In this regard, state officials from Montana, Maryland, and New Jersey testified to the many and varied reform efforts that have been blocked by ERISA preemption, particularly with respect to self-funded plans.<sup>323</sup>

In 2007, ERISA waivers may have been the most that could be hoped for given Congress’s longstanding resistance to wide scale

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321. *Id.*

322. *Id.*

323. *Id.* at III. <http://edworkforce.house.gov/hearings/help052207.shtml>

health reform. However, when President Obama took office, things looked quite different. After all, Massachusetts had already seen more than 400,000 formerly uninsured persons obtain coverage<sup>324</sup> with employers remaining in-state and in the business of insuring their workers.<sup>325</sup> During the first half of 2009, such promise, combined with economic recession, relentless cost escalation, and rising unemployment adding to the nation's 47 million of uninsured<sup>326</sup> generated broad political and public consensus that the time had come to accomplish comprehensive reform at the national level.<sup>327</sup>

Not surprisingly, however, political consensus quickly splintered in the face of the devil in the details of expanding coverage and controlling costs while preserving if not improving quality. Unlike President Clinton who charged his wife with chairing a task force to design a complex and ultimately failed proposal,<sup>328</sup> President Obama articulated eight guidelines for

324. In its May 2009 quarterly report on Health Care in Massachusetts, the Massachusetts Division of Health Care and Finance and Policy reported an increase of 428,000 people in private or subsidized health care plans (excluding Medicare beneficiaries) since the state's reforms took effect in June, 2006. MASS. DIV. OF HEALTH CARE AND FIN. POLICY, HEALTH CARE IN MASSACHUSETTS: KEY INDICATORS 3 (2009), available at [http://www.mass.gov/EOHHS2/docs/dhcfp/r/pubs/09/Key\\_Indicators\\_May\\_09.pdf](http://www.mass.gov/EOHHS2/docs/dhcfp/r/pubs/09/Key_Indicators_May_09.pdf).

325. In its December 2008 analysis of 2007 employer survey data, the Massachusetts Department of Health Care Finance and Policy indicates that rates of employer sponsored health benefits have remained stable in Massachusetts following implementation of state reform, while national employer sponsored coverage rates have declined. MASS. DIV. OF HEALTH CARE AND FIN. POLICY, MASSACHUSETTS EMPLOYER SURVEY 2007 4 (2008) available at [http://www.mass.gov/EOHHS2/docs/dhcfp/r/pubs/08/employer\\_report\\_2007.ppt](http://www.mass.gov/EOHHS2/docs/dhcfp/r/pubs/08/employer_report_2007.ppt). See also Sharon K. Long & Paul B. Masi, *How Have Employers Responded To Health Reform In Massachusetts? Employees' Views At The End Of One Year*, 27 HEALTH AFFAIRS w576, w576 (2008) (employee survey results confirm that employers made no significant changes in coverage following enactment of state health reform).

326. See, e.g., Todd P. Gilmer and Richard G. Kronick, "Hard Times and Health Insurance: How Many Americans Will be Uninsured by 2010?" 28 HEALTH AFFAIRS AFF. w-573 (web exclusive 2009) (predicting that, absent major changes in current policy, the number of uninsured in America will grow by 6.9 million just due to higher coverage costs (increasing from 17.2% in 2007 to 19.2% - or 52 million - by 2010) with "more millions" losing coverage due to job losses).

327. See, e.g., KRISTOF STREMKIS ET AL., HEALTH CARE OPINION LEADERS' VIEWS ON PRIORITIES FOR THE OBAMA ADMINISTRATION ("The Commonwealth Fund/Modern Healthcare Health Care Opinion Leaders Survey: Views on Priorities for the Obama Administration, January 2009," <http://www.commonwealthfund.org/Content/Surveys/2008/The-Commonwealth-Fund-Modern-Healthcare-Health-Care-Opinion-Leaders-Survey--Views-on-Priorities-for.aspx> (last visited Oct. 26, 2009) (a survey of 194 "[p]eer-nominated experts in health care policy, finance, and delivery; select members of the Modern Healthcare database" suggests that "President Obama enjoys a strong mandate for major elements of the health care reform proposal unveiled during the 2008 presidential campaign."); Jim Cooper and Michael Castle, "Health Reform: A Bipartisan View," 28 HEALTH AFF. AIRS w-169 (web exclusive March 2009) ("Political and policy factors suggest that President-elect Barack Obama is in a much better position than his predecessors to achieve comprehensive health reform, including universal coverage."); Sheryl Gay Stolberg, *Obama Taps Clinton Ideas but Not Clinton Herself*, N.Y. TIMES, 19, (Mar. 5, 2009) ("Experts say the political climate for passing major health care changes is more favorable than ever, with business leaders, pharmaceutical and hospital executives, insurance officials and advocates for patients all agreeing the need is urgent.").

328. See generally *The Politics Of Health Reform: A Collection Of Perspectives*, 27 HEALTH AFFAIRS 688 (2008); Walter A. Zelman, *The Rationale Behind the Clinton Health Care Reform Plan*, 13 HEALTH

“comprehensive health reform,”<sup>329</sup> but put Congress in charge of the logistics.<sup>330</sup> In a year when the economy continues to stumble and all 435 members of the House and one third of 100 Senators are up for reelection, there is little appetite for hitting voters in their wallets. Consequently, even Democrats have resisted President Obama’s initial idea of imposing a broad-based income tax on employer sponsored health benefits<sup>331</sup> or a more limited tax on the affluent<sup>332</sup> to fund reform. Requiring individuals to have insurance has also gained little traction even though the Congressional Budget Office lists “enforceable individual mandates” as necessary for achieving universal coverage.<sup>333</sup> And the President’s idea of creating a public plan to compete with private payers was at one point described by Senator Grassley (Republican, Iowa) as “a deal breaker for Republicans if it’s in, and . . . a deal breaker for Democrats if it’s not[.]”<sup>334</sup> With members of Congress launching new proposals, attacks and counter-attacks each day, it is becoming increasingly clear that federal action, if any, will be scaled back from the comprehensive reform that finally seemed within reach when President Obama

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AFFAIRS 9 (1994).

329. The Administration’s initial goals for “comprehensive health reform” were to: 1) reduce costs; 2) protect against health-care related bankruptcy; 3) guarantee choice of providers and plans; 4) promote prevention and wellness; 5) improve the safety and quality of care; 6) “assure affordable, quality care for all Americans”; 7) ensure portability of coverage; 8) end pre-existing conditions exclusions. WHITE HOUSE, Health Care, [http://www.whitehouse.gov/issues/health\\_care/](http://www.whitehouse.gov/issues/health_care/) (last visited Oct. 26, 2009) (emphasis added).

330. See, e.g., Laura Meckler, *Congress is Left to Flesh Out the Details*, WALL ST. J., May 19, 2009, at A4 (discussing the President’s “unusual approach” of “laying out the big picture, and letting lawmakers fill in critical details”); Robert Pear, *Obama’s Health Plan, Ambitious in Any Economy, Is Tougher in This One*, N.Y. TIMES, March 2, 2009, at 14.

331. See, e.g., Carrie Budoff Brown & Chris Frates, *Harry Reid Jumps Into Health Negotiations*, POLITICO.COM, July 7, 2009, <http://www.politico.com/news/stories/0709/24676.html> (noting participants in the Senate were having “second thoughts about taxing health benefits, which would raise \$340 billion over 10 years” but revealed as “highly unpopular” in public polling); *Key Senate Panel Struggles To Reach Consensus*, KAISER HEALTH NEWS, July 20, 2009, <http://www.kaiserhealthnews.org/Daily-Reports/2009/July/20/Senate-Monday.aspx>; *House Face-off Looms Over Sweeping Health Bill*, KAISER HEALTH NEWS, July 20, 2009, <http://www.kaiserhealthnews.org/Daily-Reports/2009/July/20/Monday-House.aspx>.

332. Alex Wayne & Jonathan Allen, *Blue Dogs Bare Teeth at Health Bill Markup*, WASHINGTON HEALTH POLICY WEEK IN REVIEW, July 20, 2009, <http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2009/Jul/July-20-2009/Blue-Dogs-Bare-Teeth-at-Health-Bill-Markup.aspx> (describing Democratic opposition to H.R. 3200’s funding provisions 2009).

333. ROBERT A. SUNSHINE, PRESENTATION TO CONGRESSIONAL HEALTH STAFF: CBO’S NEW HEALTH REPORTS, 10 (December 2008), available at <http://www.cbo.gov/ftpdocs/99xx/doc9924/SlidesHealthBriefing.pdf> (last visited Oct. 26, 2009); see also, CONG. BUDGET OFFICE, KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS, 1 (December 2008), available at <http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf> (last visited Oct. 26, 2009).

334. Drew Armstrong, *Grassley Says Public Insurance Option Is Thorniest Health Care Issue*, WASHINGTON HEALTH POLICY WEEK IN REVIEW (Mar. 19, 2009), <http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2009/Mar/Washington-Health-Policy-Week-in-Review-March-23-2009/Grassley-Says-Public-Insurance-Option-Is-Thorniest-Health-Care-Issue.aspx> (last visited Oct. 26, 2009).

assumed office.

Nevertheless, even broad-based reform will not completely erase ERISA preemption's detrimental impact on the large majority of patients and providers who deal with employer-sponsored health care. Congress might very well follow Massachusetts' lead and require individuals to obtain coverage, and also mandate employers to "play or pay" in covering their workers (the latter of which is vulnerable to ERISA preemption when required by states).<sup>335</sup> Congress may insist that certain benefits be offered, and put an end to various exclusions—measures that, if mandated by states, would be preempted when applied to employer-sponsored plans, especially those that are self-insured. Such actions would expand coverage, improve access and maybe even contain costs.

However, none would do a thing to protect patients from falling into ERISA's remedial vacuum for harms resulting from MCO medical necessity determinations for employer sponsored plans. None would help providers who rendered care but need to overcome costly ERISA barriers to payment. In addition, none would help states whose traditional role in overseeing health care would likely be viewed as more fragmented and muddled than ever. Reform should not only bring change, it should bring improvement even if only through clarification of roles, rights and remedies of the various players. It is fair to say that, at least so far, the outlook is less than promising.

Perhaps the sole point of agreement among the President and his opponents is their determination to avoid "the preemption thicket"<sup>336</sup> by leaving both state remedies *and* sections 502 and 514 intact.<sup>337</sup> For instance, section 132 of "The Affordable Health Choices Act" that passed in the House and the Senate Health, Education, Labor and Pensions Committee in July 2009 provides for internal and external review of coverage and medical necessity disputes. Ideally, a provision of this kind could reduce the kinds of injuries that occurred in *Corcoran*<sup>338</sup> and *Danca*<sup>339</sup> discussed above. Still, state law remains intact unless otherwise provided although "[n]othing . . . shall be construed as affecting the

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335. See *supra* notes 267 and 274, and accompanying text.

336. *Memorial Hospital v. Northbrook*, 904 F.2d 236, 2448 (5th Cir. 1990), discussed *supra* note 222.

337. For instance, in the H.R. 3200 "Affordable Health Choices Act," § 151(a)(1) states that, unless otherwise provided, the requirements of the overall Act "do not supercede . . . [ERISA], or State law" subject to § 151(a)(2)'s qualification that "[n]othing in [§ 151(a)(1)] shall be construed as affecting the application of section 514 of [ERISA]." H.R.3200, 111th Cong. § 151(a)(1) (2009) *available at* <http://thomas.loc.gov/cgi-bin/query/F?c111:1:/temp/~c111Mnq9NO:e62784>: (last visited Oct. 26, 2009).

338. See *supra* notes 61 and 71, and accompanying text.

339. See *supra* notes 134 and 139, and accompanying text.

application of section 514 of [ERISA].” On its face, preserving state law seems reasonable except for the sad fact that, once a patient has been injured, ERISA preempts state law remedies, and ERISA’s equitable remedies are futile post-injury.<sup>340</sup>

The 107th Congress came close to filling the ERISA vacuum when it was scheduled to debate and vote on the “Bipartisan Patient Protection Act”<sup>341</sup> following its August 2001 recess. The major sticking point was whether patients would be able to recover compensatory damages for harm proximately resulting from MCO medical necessity determinations or other benefit denials or delays. Coming shortly after the U.S. Supreme Court’s *Pegram* decision and before that Court’s hairpin turn in *Rush*, the Senate’s more generous version was seen as “basically following the approach suggested by *Pegram*, allowing state courts to apply traditional malpractice norms to claims that unreasonable medical decisions by MCOs have contributed to death or disability.”<sup>342</sup> Despite a general consensus that some version of the bill would pass, it was not at all clear whether patients would have better remedies.

What soon became clear was that no part of the bill could survive the September 11, 2001 attacks. At that point, matters of national security became all consuming, patients’ rights toppled from the legislature’s agenda and, as described earlier, *Pegram*’s promise of available state remedies evaporated with *Davila*’s resuscitation of broad ERISA preemption.<sup>343</sup> It has taken eight years for health care to reemerge as a domestic priority, but fixing ERISA preemption is no longer on the legislative wish-list. Yet, as evidenced by the Supreme Court’s post-*Pegram* preemption decisions of *Davila* and *Wyeth*, the ERISA preemption thicket is more confounding than ever.

Like too many aspects of health care in America today, the preemption of remedies problem is getting worse, not better, and not just for patients, but—as explained above—for providers and states, too. If nothing is done to fill ERISA’s remedial vacuum, and employers are mandated or incentivized to expand health benefits, more patients will be covered by ERISA-qualified health benefits plans. As a result, more patients will have no meaningful remedy after sustaining harm due to an MCO’s decision. This could also mean that more health care providers, already struggling with declining reimbursement rates, will need to spend valuable time challenging treatment denials and, after rendering

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340. See *supra* note 106 and accompanying text.

341. S.1052 107th Cong. (2001); H.R. 2563, 107th Cong. (2001).

342. Sylvia A. Law, *Do We Still Need a Federal Patients’ Bill of Rights?*, 3 YALE J. HEALTH POL’Y L. & ETHICS 1, 310 (2002).

343. See *supra* notes 237-41 and accompanying text.

care, face more difficulty in getting paid. And all of this will be the direct result of the continuing ability of MCOs to invoke section 502 and section 514 preemption to evade accountability to patients and providers alike.

It may be a harsh reality, but it is reality nonetheless to say that Congress needs to reform ERISA preemption or liberalize the availability of state ERISA waivers. It could fix ERISA by clarifying the scope of preemption with regard to the kinds of coverage and medical necessity decisions that result from the integration of finance and delivery of health care. It must state explicitly whether state compensatory remedies are available. If state remedies are not available, it must include them in ERISA itself by amending section 502's civil enforcement scheme.

It is far more likely, however, that overt ERISA reform will prove impractical due to the need to conserve political capital at a time of unprecedented challenges at home and abroad and a deepening divide over whether and how to undertake federal health care reform. For this reason, Congress should look to ERISA waivers as critical to any next step. If comprehensive federal reform collapses in whole or significant part, allowing state experimentation will offer the best promise for figuring out how to fix the health care system since it is broken in so many places and in so many ways. Waivers would also allow much needed flexibility since what might work for one state or region may not be suited to the economy or geography of another—a realization that will not be new to Congress since it granted a waiver to Hawaii when it initially passed ERISA.<sup>344</sup> And finally, waivers would allow states to do what federal law currently does not: accord some form of protection to both patient and provider as Congress fights its way to more comprehensive reforms.

### III. CONCLUSION

President Obama had hoped that the weeks leading up to August 2009's congressional recess would be marked by consensus, compromise, and ultimate passage of a health reform bill. Unfortunately, consensus was displaced by conflict, compromise ceded to impasse, and civil discourse among a bipartisan Congress devolved to increasingly strident dissent. In mid-July, Senator Jim Demint (Republican – S.C.) assured the group "Conservatives for Patient Rights" that "this health care issue is D-Day for freedom in America" and "if we're able to stop Obama on this it will be his Waterloo. It will break him."<sup>345</sup> A few

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344. See, e.g., John Colmers *supra* note 318, at 28 (statement of John Comers, Secretary, Maryland Dept. of Health and Mental Hygiene).

345. Ben Smith, *Health Reform Foes Plan Obama's 'Waterloo'*, POLITICO.COM, (July 17 2009),

days later, President Obama responded:

This isn't about me. This isn't about politics. This is about a health care system – a health care system that is breaking America's families, breaking America's businesses and breaking America's economy, and we can't afford the politics of delay and defeat when it comes to healthcare – not this time, not now. There are too many lives and livelihoods at stake. There are too many families who will be crushed if insurance premiums continue to rise three times as fast as wages. There are too many businesses that will be forced to shed workers, scale back benefits, or drop coverage unless we get spiraling health care costs under control.<sup>346</sup>

It is true that lives and livelihoods are at stake. Perhaps it should not be about politics, but in this country, it is all about politics when it comes to making policy, and it is all about the intricacies of legislation when it comes to putting policy into practice. It is true that there is much to be done to fix health care in America, and improving the "Four Cs" of "coverage, cost control, coordinated care, and choice" is undoubtedly essential.<sup>347</sup> Not unrelated, however, is the way in which ERISA – an employee protective statute – has been wielded by payers to avoid accountability, and erratically interpreted by the courts to permit if not promote this absurd result. Health care reform without ERISA preemption reform or waivers runs the risk of leaving patients with no remedies and providers with no pay. It also curtails the ability of states to do much about it. All of these concerns are troubling, but the latter is surely the most disturbing. After all, it is understandable if Congress's plate is too full to take this on, but it is unforgiveable if Congress will not allow the states to try.

On March 21, 2010, the U.S. House of Representatives passed the Reconciliation Act of 2010, H.R. 4872 which will initiate insurance reforms, individual mandates and employer "play or pay" incentives. Although subsequent amendments are expected, section 251(a) currently permits a state to seek an ERISA waiver for the purpose of implementing a single payer system. Otherwise, ERISA preemption, along with its complexities and problems, remains intact and is likely to grow more confounding for states, providers, and patients as the new law takes effect.

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available at [http://www.politico.com/blogs/bensmith/0709/Health\\_reform\\_foes\\_plan\\_Obamas\\_Waterloo.html?showall](http://www.politico.com/blogs/bensmith/0709/Health_reform_foes_plan_Obamas_Waterloo.html?showall) (last visited Oct. 26, 2009).

346. Huma Khan & Jonathan Karl, *Dems Waver on Obama's August Health Care Deadline*, ABC NEWS (July 21, 2009) available at <http://www.abcnews.go.com/Politics/story?id=8134131&page=1> (last visited Oct. 26, 2009).

347. See *supra* note 4 and accompanying text.